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including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug. **Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis,

epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with over-dosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-070-G

Serious side effects do occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions.

For complete details, including dosage, please see full prescribing information.

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Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions, symptoms of blood dyscrasia; dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty. **Indications:** Acute gouty arthritis, rheumatoid arthritis, hematomatoid spondylitis. **Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy. **Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias,

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MARYLAND AREA

- Feb 25-27 **Topics in Neurology**, Dept of Neurology, Johns Hopkins Hosp. Crs designed to relate new info on basic mechanisms of disease to diagnosis & mgt of clinical problems. Limited to 125. Contact: John M Freeman, CMSC 801, Johns Hopkins Hosp, 601 N Broadway, Baltimore Md 21205.
- Mar 1-April 5 **Univ of Maryland Sch of Medicine**, Baltimore. 2nd series of 6 consecutive Thursdays of selected topics in gen & family practice. Prepare for board exams or recertification. 15 hrs or AAFP. Contact: Univ of Md Sch of Med, Comm on Continuing Med Educ, Baltimore Md 21201, 528-7346.
- Mar 5- 9 **Ophthalmic Pathology**. Washington. Sponsors: ACR & AFIP. Contact: Director, Armed Forces Inst of Pathology, Washington DC 20305.
- Apr 25-27 **Med-Chi 175th Anl Mtg**, Civic Center, Baltimore.

AMERICAN COLLEGE OF PHYSICIANS

(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104.)

- Feb. 26-Mar 2 **Clinical Gastroenterology**, Univ of Michigan Med Cen, Ann Arbor.
- Mar 5-8 **Problems of International Health**, Naval Hosp, San Diego, LeBaron Hotel, San Diego.
- Mar 5-8 **Modern Neurological Diagnosis & Therapy**, Univ of Miami, Edin Roc Hotel, Miami Beach.
- Mar 12-16 **Infectious Diseases**, Univ of Maryland Sch of Med, Baltimore.
- Mar 14-16 **Clinical Pharmacology—Rational Basis of Therapeutics**, Univ of Calif Sch of Med, San Francisco.
- Mar 19-23 **Internal Medicine: What's New?** Univ of Alabama Med Cen, Birmingham.
- Mar 22-24 **Clin Recognition & Mgt of Heart Disease 1973**, Arizona Med Cen Hosp, Tucson Ariz.
- Mar 26-30 **Cardiology 1973**, Topics of Current Interest. Mt Sinai Sch of Med, New York City, Americana Hotel.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

(For info on these mtgs, contact ASA, 515 Busse Highway, Park Ridge, Ill 60068.)

- Feb 17-20 **18th Anl Postgrad Anesthesiology Crs**, Univ of Utah Col of Med, Park City Utah.
- March **Anesthesia for Cardiovascular Surgery**, Texas Heart Inst, Texas Med Cen, Houston.
- Mar 11-15 **47th Congress—International Anesthesia Research Society**, Americana Hotel, Bal Harbour Fla.
- Mar 17-18 **Pediatric Anesthesia**, Univ of Tennessee Col of Med, Memphis.
- Mar 24 **14th Anl Postgrad Anesthesia Seminar—NJ State Society of Anesthesiologists**, Cherry Hill Inn NJ.
- Mar 24-25 **ASA Workshop on Fluid & Transfusion Therapy**, Fairmont Hotel, Dallas.

MISCELLANEOUS MEETINGS

- Feb 2- 3 **8th Anl San Francisco Cancer Symposium**, Mt Zion Hosp & Med Cen, San Francisco, \$50 fee. Contact Harry Weinstein MD, Mt Zion Hosp & Med Cen, Box 7921, San Francisco Calif 94120.
- Feb 15-16 **International Med Assembly of Southwest Texas**, San Antonio. ACFP credits. Contact: IMAST, 202 W French Place. San Antonio Tex 78212.
- Feb 22-24 **American Col of Hosp Administrators**, 16th Congress on Admin, Palmer House, Chicago. Contact: ACHA, 840 N Lake Shore Dr, Chicago Ill 60611.
- Feb 24-28 **Aspen Seminar on Diagnostic Radiology of Urinary Tract**, Sponsor: Louisiana State Univ Sch of Med Det of Radiology. Contact: EK Lang, LSU Med Cen, PO Box 3932, Shreveport, La 71130.

- Feb 25-Mar 3 **Amer Society of Contemporary Med & Surgery**, anl mtg, Fountainbleu Hotel, Miami Beach. Continuing med educ crs. Contact: Va Kendall, Suite 1629, 30 N Michigan Ave, Chicago Ill 60602.
- Feb 25-Mar 1 **Pediatric Cardiopulmonary Care**, Amer Col of Chest Physicians & Pediatric Pulmonary Dept, Univ of Colorado Med Cen, Aspen Col. Contact: AACP, 112 E Chestnut St, Chicago Ill 60611.
- Feb 26-Mar 2 **Mgt of Acute Cardiorespiratory Failure**, Amer Col of Chest Physicians & Univ of Miami Sch of Med, Miami. Contact: AACP, 112 E Chestnut St, Chicago Ill 60611.
- Mar 5-10 **Crs in Laryngology & Bronchoesophagology**, Chicago. Sponsor: Abraham Lincoln Sch of Med & Univ of Illinois Hosp Eye & Ear Infirmary. Crs limited to 15. Contact: Dept of Otolaryngology, Eye & Ear Infirmary, 1855 W Taylor St, Chicago Ill 60612.
- Mar 12-16 **166th Anl Postgrad Crs in Diagnostic Radiology**, San Francisco, \$150 fee. Contact: Dept of Cont Educ in Hlth Sciences, 570-U, Univ of Calif, San Francisco Calif 94122.
- Mar 15-16 **22nd Anl Postgrad Crs in Pediatrics**, Galveston Tex. 12 hrs AAGP. \$75 regis fee. Contact: Lillian H Lockhart MD, Dept of Pediatrics, Univ of Texas Med Branch, Galveston Tex 77550.
- Mar 19-22 **Controversial Issues in Pediatric Cardiology Symposium**, Miami. Contact: Div of Cont Educ, Univ of Miami Sch of Med, PO Box 875, Biscayne Annex, Miami Fla 33152.
- Mar 26-29 **Crs in Neurology**, Chicago. Sponsor: Abraham Lincoln Sch of Med & Univ of Illinois Hosp Eye & Ear Infirmary. Limited to 12. Contact: Dept of Otolaryngology, 1855 W Taylor St, Chicago Ill 60612.
- Mar 26-31 **Selected Topics in Genitourinary Roentgenology**, Playboy Plaza Hotel, Miami Beach. Contact: Manuel Viamonte MD, Det of Radiology, Univ of Miami Sch of Med, Box 875, Biscayne Annex, Miami Fla 33152.
- Mar 29-30 **26th Natl Conf on Rural Health**, Statler-Hilton Hotel, Dallas. Contact: Dept of Rural Health, Div of Med Practice, 535 N Dearborn St, Chicago Ill 60610.
- Mar 29-31 **National Conf on Urologic Cancer**, Shoreham Hotel, Washington. No regis fee. Sponsor: Amer Cancer Society. Contact: Sidney L Arje MD, Natl Conf on Urologic Cancer, c/o ACS, 219 E 42nd St, New York NY 10017.

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A detailed program will be mailed to all members
of the Faculty and to others upon request

Med-Chi Salutes

THE MEMORIAL HOSPITAL AT EASTON, MD INC

The Memorial Hospital at Easton, Md Inc is a 226-bed, community, private nonprofit, acute general hospital serving Talbot, Caroline, and Queen Anne's counties. It was founded in February 1907 by two graduate nurses, Mary Bartlett Dixon and Elizabeth Wright. The Hospital's School of Nursing was founded at the same time with an enrollment of three students. It is the only fully accredited School of Nursing in Maryland outside of Baltimore offering a 32-month diploma program.

The active medical staff numbers 29, supported by an associate staff of eight and courtesy staff of four. There is a consulting staff of 17. In addition to the staff physicians engaged in General Practice and Surgery, the specialties of Obstetrics and Gynecology, Anesthesiology, Internal Medicine, Pediatrics, Ophthalmology, Urology, Radiology, Orthopaedics, Otolaryngology, Pathology, Neurology, Allergometry, Psychiatry, and Dermatology are well represented.

The Hospital has a School of X-ray Technology and conducts courses in Medical Technology in cooperation with Chesapeake College. Employees are offered in-training programs to expand the scope of their careers.

Memorial Hospital's physical expansions and added services over the years have kept pace with the growing population and the advances in medical science, creating a facility offering the finest and most modern in patient care.

In the past five years admissions of both inpatients and outpatients has greatly increased, particularly the outpatient census which has risen from 27,700 to 47,100, and bed patients to about 9,000 . . . facts that reflect the nationwide shortage of general practitioners in the medical profession, resulting in the increasing use of community hospitals for diagnosis and treatment.

Several recent projects at Memorial Hospital indicate the wide perspective of its Board of Directors. A group of garden apartments for rental to Hospital personnel was opened the end of 1972. These apartments, built just a block from the Hospital are offered at nonprofit rentals. An Extended Care Unit was also completed in 1972 on the fifth floor of the Hospital's \$6 million South Wing, four floors of which were opened in 1969.

Some outstanding services were recently initiated. The Pharmacy added a clinical pharmacist to its staff to work with the medical staff in evaluating the reactions and compatibility of drugs prescribed by the physician for his pa-



FIRST BUILDING—The original Memorial Hospital at Easton was known as the Emergency Hospital, when founded in 1907. The building still stands at South Washington and Dover streets in Easton.

tients. The ever-increasing introduction of new drugs makes this kind of research vitally important to the patient's welfare.

Memorial's Intensive Care Coronary Care Unit has added a telemetry system to its already highly efficient equipment. Telemetry is the system used by the astronauts to make contact with radio and television broadcasts. It permits a patient's removal from IC-CCU, when past the acute stage of illness, to an adjacent room. However, the patient, though mobile, continues to have the close surveillance of monitoring in the Unit through electrodes carried on his person. Thus, the patient is psychologically encouraged toward recovery and an IC-CCU bed is released for a more acutely ill patient.

In 1972 the Macqueen Gibbs Willis School of Nursing, also founded in 1907, was honored by receiving a seven-year accreditation from the National League for Nursing in the Department of Diploma Programs. This is the maximum accreditation granted by the League. The School's present enrollment of 70 students is the highest in its history.

In order to continue its record of excellence in serving its community a Planning Committee of the Board of Directors, assisted by each department head of the Hospital, meets regularly in order to project the future needs of Memorial and plan for their fulfillment.

Memorial Hospital is located on Washington Street in Easton. Nick Rajacich is hospital administrator; Vincent O Eareckson MD is chief of staff.

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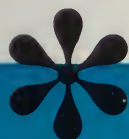
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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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To help you manage excessive psychic tension

your medical faculty at work

by John Sargeant, Executive Director

The Executive Committee met on Thursday, Nov 16, 1972 and took the following actions:

- 1) Met with representatives of the Health Services Cost Review Commission and discussed the request of the Commission for financial data on physicians who receive remuneration from hospitals.
- 2) Met also with representatives of statewide specialty groups whose members receive such remuneration. It was unanimously agreed that the Faculty did not oppose revealing such information but that it be presented in its proper perspective that is in relation to total costs of hospital care and indications as to whether the figures are net or gross.
- 3) Adopted the House of Delegates minutes of the Sept 15, 1972 semiannual session.
- 4) Heard that students at both medical schools were finding it difficult to designate a representative to the Faculty's House of Delegates meetings who is a junior or senior, and declined to approve a request that freshmen or sophomores be permitted to serve in this capacity. To do so would be a violation of Faculty bylaws.
- 5) Declined to subsidize representatives of the Student AMA chapters to attend the AMA clinical session in Cincinnati, Ohio because regular subsidies are provided to both local chapters on an annual basis.
- 6) Appropriated funds from the Educational Fund to send a copy of the Allied Medical Education Directory to all high schools in the State. The cost would total approximately \$80.
- 7) Approved a proposed questionnaire for survey of nonmembers of the Faculty to be used on a pilot basis and to be surveyed through members of the Executive Committee.
- 8) Heard that the AMA Committee on Long-Range Planning will probably schedule a regional meeting in Washington, DC sometime in February 1973.
- 9) Approved an increase in annual retainer for legal counsel to start with the calendar year of 1973.
- 10) Authorized the designation of Aubrey W Richardson MD to represent the Faculty at a regional AMA-sponsored meeting on the Role of the Medical Director in the Long-Term Care Facility.
- 11) Approved submission of Various Faculty members' names to Maryland Blue Cross for appointment to Physicians' Review Committees.
- 12) Received copies of the Regional Planning Council Report on Health Issues and Recommendations with the understanding that any comments or suggestions should be reported to the Faculty office.
- 13) Discussed a request from the Washington County Medical Society regarding the Western Maryland Hospital, a chronic disease facility, and offered to meet and discuss this further if the Society so wishes. Data and responses to requests in this regard had already been forwarded to that component.
- 14) Authorized an evaluation of the employee pension program to ensure that maximum benefits are being obtained through the present funding system.
- 15) Received and acknowledged a communication from the Baltimore City Medical Society regarding the use of educational funds for an informational newsletter published by MMPAC.
- 16) Rereferred to the Subcommittee on Child Welfare its recommendations with respect to the Crippled Children's Program and suggested that they contact the Department of Health and Mental Hygiene for further discussions in this regard.
- 17) Deferred action on appointment of a Faculty representative to serve on the Advisory Board, County Cablevision Inc until it learned what the Board would do and what purposes a physician would serve in being selected for this activity.
- 18) Authorized attendance of the President-elect and Executive Director at a National Leadership Conference scheduled by the AMA for Chicago on Feb 16-18, 1973.

- 19) Deferred to the next Executive Committee session a suggestion that a list of suit-prone patients be published for information of physicians.
- 20) Approved the mailing of blood bank assurance literature to all physicians in the Metropolitan Baltimore area. The material would be provided at no cost to the Faculty.

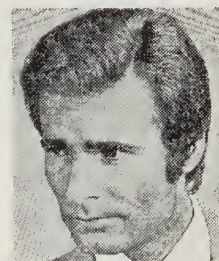
The Council met on Thursday, Nov 16, 1972 and took the following actions:

- 1) Adopted minutes of various previous meetings.
- 2) Approved recommendations for Emeritus Membership to the House of Delegates of various physicians recommended by their component societies.
- 3) Deferred discussion until the next Council session of a proposed arbitration plan for professional liability cases because of lack of complete data in this regard.
- 4) Approved financial statements through September 30, both operating and dedicated funds.
- 5) Designated the Executive Director as Legislative Agent for the 1973 General Assembly session.
- 6) Heard that the sales contract was due to be signed shortly for purchase of 20 acres of land in Howard County. Also heard that the Baltimore City Medical Society has expressed concern over the possible move of the Faculty building to Howard County as has the Mayor of Baltimore City.
- 7) Requested a complete financial report on the status of the so-called Ash project, with figures as to income and expenses over the period of this activity. This project dealt with weeding out surplus library material and reclassifying the rare book collection.
- 8) Approved a recommendation from the Committee on Emergency Medical Services suggesting no action be taken with respect to a suggestion from the Secretary of Health and Mental Hygiene in connection with a pool of elite trauma physicians and emergency medical technicians to accompany public figures in their appearances at large gatherings in Maryland. Offered, however, to assist staff personnel of such public figures in acquainting them with information and other data in connection with emergency health services in the State.
- 9) Heard that the Maryland Foundation for Health Care has had incorporation papers filed and has held its first board meeting and elected officers.
- 10) Heard that HR1, the omnibus Medicare and Medicaid bill, has been signed into law by the President. Chiropractic Services have been included under Medicare by this legislation, although it is understood that such services will cover treatment for only "subluxation" of the spine, which must be demonstrated by X-ray. Such X-ray cannot be taken by a Chiropractor.
- 11) Deferred action on a request from the Maryland Nurses Association for Faculty endorsement of a grant proposal to study nursing in Maryland.
- 12) Approved the use of MD license plates in Maryland for those physicians desiring to use such plates; also approved a request to the Department of Motor Vehicles that would restrict the use of the MD series to physicians in Maryland only. It is recognized that this probably cannot be done until new plates are issued, probably sometime in 1975 or 1976.
- 13) Authorized the Council Chairman to designate nominees to serve on FDA advisory panels dealing with effectiveness of OTC preparation and antiperspirant vaginal drugs.
- 14) Authorized the Program and Arrangements Committee to change 1974 semiannual meeting dates if in its opinion such a change is necessary.

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Medical Miscellany

EEG Guidelines

The American Electroencephalographic Society announces the availability of a new series of publications, "GUIDELINES IN EEG" with information of potential use to physicians, technologists, nurses, hospital administrators, and others directly or indirectly concerned with electroencephalography. Three titles are presently available: 1) "Minimum Technical Standards for EEG Recording in Suspected Cerebral Death," 2) "Minimum Technical Requirements for Performing Clinical Electroencephalography," and 3) "Standards of Practice in Clinical Electroencephalography." Other titles will be added to the series in time. Copies of the GUIDELINES are available for \$1.00 each (to help defray printing and postage costs) upon request to:

Mrs. Margaret H. Henry, Executive Secretary
The American EEG Society
36391 Maple Grove Rd
Willoughby Hills, Ohio 44094.

FLU SHOTS?

Elderly persons, and persons employed in high-risk occupations should receive influenza shots, Dr John D Stafford, Chief of the Division of Communicable Diseases, Maryland Department of Health and Mental Hygiene advises.

Dr Stafford defined high-risk occupations as those including persons in medical and paramedical professions, public safety, public utilities, and other specialized public services.

While an outbreak of Hong Kong Influenza is not expected this winter, Dr Stafford has predicted the appearance of a type termed A/England/42/72, based on patterns of influenza occurring in other areas of the world.

"Although influenza vaccines now in use do provide a large degree of immunity," he said, "they cannot confer absolute immunity from the disease. However, recent improvements render this year's vaccine more effective than that used in prior years.

"We do not recommend annual influenza immunization for every individual," he continued, "but it is definitely indicated for certain high-

risk groups which in the past have shown severe illness from the disease."

The vaccine is recommended for all persons over 65 years of age, and for the chronically ill of all ages who suffer from heart, lung, kidney diseases, or from diabetes.

Persons living in nursing homes, chronic disease hospitals, and other medical institutions where living arrangements may facilitate the spread of the disease once it is introduced, should also have the vaccine.

Vaccination against influenza is not recommended for children, Dr Stafford said, unless they fall in the high-risk group of the chronically ill. He also said persons sensitive to eggs or egg products should not receive the vaccine.



PRACTICAL AUTOMATION FOR THE CLINICAL LABORATORY, 2nd Edition, by Wilma L White, Marilyn M Erickson and Sue C Stevens, The CV Mosby Company, St Louis, 1972.

This book is a worthwhile tool for all laboratory personnel to review, have available for reference, and to use in upgrading their skills and ability in connection with laboratory techniques. The authors are experts in their particular fields and it contains a summary of their judgments, as well as those of the consultants on whom they called. New to the revised edition are sections on blood bank, microbiology, hematology, and cytology. We can heartily recommend the purchase of this book for all laboratories if for nothing else than as a reference work.

DEVELOPMENTS IN HORNEY PSYCHOANALYSIS, a selection of articles from the *American Journal of Psychoanalysis*, 1950-70; by Jack L Rubins MD, Robert E Krieger Pub Co, Huntington NY, 1972.

This book illustrates the development of the theories of neurosis and personality development as expounded by Karen Horney MD over the past 20 years. It presents interesting reading to those who may be interested in psychoanalysis and other aspects of care referred to in this publication.

Medicare Changes

Under a ruling from the Price Commission, a required increase in the Medicare hospital deductible was cut in half from \$8 to \$4, HEW officials report.

Beginning January 1, a Medicare beneficiary will be responsible for the first \$72 (up from \$68) of his hospital bill, a reduction of 5¼% from the rate which otherwise would have applied.

Prior to formal announcement of the 1973 rate, Secretary Richardson said he asked the Cost of Living Council to determine if the hospital deductible was subject to the provisions of the Economic Stabilization Program. The Council ruled that the deductible represents a price paid by Medicare recipients for hospital services and that it is, therefore, governed by Price Commission regulations limiting the increase in prices which can be charged by institutional providers of health services. The Commission held the increase to 6%.

Medicare's hospital deductible is subject to periodic adjustment to reflect changes in average daily costs of hospital care under the program. The current increase, based on 1971 data, reflects in part costs incurred prior to the Economic Stabilization program and includes cost increases resulting from more advanced and expensive technology in hospitals as well as general increases in costs of goods and services.

Secretary Richardson said that when the hospital deductible amount changes on January 1 of each year, the law requires that comparable changes be made in the dollar amounts a Medicare benefici-



PREVIEW—Councilman William J. Meyers (Baltimore City, 6th Dist) and Mrs. Meyers were among more than 300 guests who attended a recent preview of the new 42-bed unit at South Baltimore General Hospital. Explaining a surgical research display (left) is Pio Vallee, MD, a surgical resident at the 408-bed hospital. An interested observer, left rear, is Chris Papadopoulos, MD, chief of cardiology and chairman of the hospital's medical staff.

ary pays toward a hospital stay of more than 60 days, or a posthospital extended care stay of more than 20 days.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay \$18 a day for the 61st through the 90th day, up from the present \$17 per day. If he has a posthospital stay of over 20 days in an extended care facility, he will pay \$9 per day toward the cost of the 21st day through the 100th day, up from the present \$8.50 per day.

If he needs to draw on his "lifetime reserve" the reserve of hospital days a beneficiary can draw upon if he ever needs more than 90 days of hospital care in the same benefit period, he will pay \$36 for each day used, instead of the present \$34 per day.

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Where He's Going**

The physician asked his 78-year-old patient to return to his office for a check-up in six

months.

"Doctor, I don't think I'll be around then," was the timid reply.

The physician straightened up.

"Nonsense. You'll be around for years yet."

The aged gentleman cleared his throat nervously.

"I mean," he said, "I'll be in Florida then. I go there every January."

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MEET YOUR NEW COUNCIL MEMBERS

This month's profiled new Council member is Marvin Ian Mones MD who is in the practice of Pediatrics and Adolescent Medicine at 9801 Georgia Ave in Silver Spring with Drs Richard Hollander and Mitchell Woldoff.

Dr Mones was elected a Councilor for the South Central District at the 1972 Annual Meeting and will assume office at the conclusion of the 1973 Annual Meeting.

He received his BS from Villanova College in 1940 and his MD from the Johns Hopkins University School of Medicine in 1947, after which he was in residency there until 1950.

Dr Mones was made a Fellow of the American Academy of Pediatrics in 1954.

He is not new to the Faculty, having served as 1st Vice President and Council member in 1969.

Since 1969 he has served as Chairman of the Maryland Chapter of the American Academy of Pediatrics.

He was Chairman, Department of Pediatrics, Holy Cross Hospital; and also served as President of the medical staff in 1965.

At Montgomery General



Dr Mones

Hospital, he served as Chairman, Department of Pediatrics. He is an attending pediatrician at Children's Hospital.

A past president of the Montgomery County Medical Society (1968), he served as Secretary in 1964.

A former Chairman of their Public Health Committee (1961), he also served as Chairman, Medical Advisory Committee to the Board of Education, 1960-1962.

Another presidency was that of the Medical Council of the DC Metropolitan Area.

In 1969 he served as Chairman, Executive and Organizing Committee, Holy Cross Hospital.

In addition to all of these activities, he also finds time to serve as Assistant Professor of Pediatrics at the Georgetown University Medical School and at George Washington University Medical School.

Dr Mones is married and has three grown children. They spend their time in entirely different directions but enjoy reunions at Cape Cod where tennis and sailing are their major interests.

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Doctors in the News

Robert J Wilder MD has been elected 1972-1973 president of the Heart Association of Maryland. He succeeds **Donald H Dembo MD**.

Other physicians elected included **Jason Geiger MD**, president-elect; **Kenneth B Lewis** and **Chris Papadopoulos**, vice presidents; and **Carlos Villafana**, **Bernard Tabatznik**, **Henry I Babitt**, **James L Trone Jr**, and **Richard I Hochman** to the board of trustees.

These elections took place at the Hunt Valley Inn in Cockeysville, where the Association recently celebrated its 25th anniversary with three days of exhibits, films, panel discussions, and social events.

The Heart Association of Maryland announces that **Nicholas J Fortuin MD**, assistant professor of medicine at the Johns Hopkins University School of Medicine, has been named to the American Heart Association's Teaching Scholarship Program.

In the program launched by the AHA in 1966, candidates are proposed by medical schools with definite programs of cardiovascular investigation and education. They are chosen for their demonstrated ability to relate to medical students, guide their education, and thus help medical careers.

During this five-year period, Dr Fortuin (one of 12 physicians so engaged) will devote essentially full time to medical teaching in the cardiovascular area.

The American College of Chest Physicians has named three Maryland physicians as

Fellows: **Walter E Dandy Jr** and **Michael L Levin** from Baltimore; and **Edward D Crockett Jr**, Silver Spring.

This special recognition by the College is conferred on physicians to mark their fulfillment of the highest professional standards in the cardiopulmonary field.

Chester W Schmidt Jr MD has been named chief of the department of psychiatry at Baltimore City Hospitals.

Dr Schmidt, formerly director of outpatient services at the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, will continue as assistant professor of psychiatry at the Hopkins.

Theodore M Bayless MD, associate professor of medicine at the Johns Hopkins University School of Medicine, has been named director of a two-year project to develop educational resources material for the teaching of the gastrointestinal and liver-related portions of medical school courses in pathophysiology.

The National Fund for Medical Education has awarded a grant for support of the project to the American Gastroenterological Association.

Dr Bayless will coordinate the activities of a number of subgroups composed of investigators and teachers on the faculties of several other medical schools.

Ey Kol Koh MD, Timonium, was recently certified as a Fellow of the American College of Anesthesiologists.

Dr John H Moxley III, dean of the University of

Maryland School of Medicine, has announced a large group of faculty appointments. All are MDs unless otherwise indicated. They include:

Malcolm Cooper, associate professor and chief of the division of nuclear medicine.

William Gill MB ChB, associate professor of surgery and clinical director of the shock trauma unit and the emergency room.

Bertram Pepper, associate professor of psychiatry.

William W Quivers Sr, associate professor of pediatrics.

John Sadler, associate professor of medicine.

Andrew Smith PhD, associate professor of pathology.

Paul Stolley, associate professor of preventive medicine.

Fitzpatrick Wilson, associate professor of obstetrics and gynecology.

Elwood H LaBrosse, **Tyson Tildon PhD**, associate professors of biological chemistry.

Sinasi Ozsoylu, **Tashiaki Sunaga**, visiting professors.

MD appointments as assistant professor included:

Ernest A Austin, surgery; **Dole P Baker**, surgery; **John M Diaconis**, radiology; **Stanley D Friedman**, medicine; **James L Frost**, pathology; **George E Gallahorn**, psychiatry; **Bruce P M Hamilton**, medicine; **Thomas E Hobbins**, medicine; **Thomas C Jones**, ophthalmology; **John N McKay**, family practice; **Charles B Payne**, medicine; **Emilio Ramos**, medicine; **Jeremy Ramp**, surgery; **Marvin P Rozear**, neurology; **Andrew Saladino**, pathology; **John M Sarges**, psychiatry; **John A Singer**, surgery; **Laszlo Steingasser**, pathology; **Tsau-Yuen-Huang**, pathology; **John P Williams**, radiology; and **Martin E Zipser**, surgery.



Dr Creamer

John J Creamer MD has been appointed chief of the ophthalmology service at South Baltimore Hospital.

Dr Creamer is assistant clinical professor, department of ophthalmology, University of

Maryland Medical School; senior attending surgeon at Baltimore's St Agnes Hospital; consultant ophthalmologist of Jenkins Memorial Hospital and St Martins Home; and on the staff of Bon Secours Hospital.

He was also recently elected secretary-treasurer of the Maryland Ophthalmological Society.

The medical staff of Baltimore's Church Home and Hospital honored Zach R Morgan MD for 50 years of service to the Hospital. Dr Morgan, recently retired from practice, was chief of staff at Church Home from 1959 until 1964.

However casually, or innocently, we first depend on a false crutch, it will likely grow on us and take hold of

our will. It is always harmful, sometimes fatal.

"The football team physician is a woman, and she's been awarded a varsity letter for her performance at Dulaney Senior High."

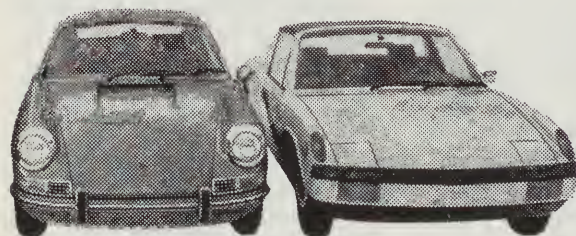
So said a feature article in the Sunday Sun of Oct 29, 1972, referring to Dr Elizabeth Sherrill.

She holds her MD from the University of Maryland School of Medicine. In 1945 she became the first female general practitioner in Baltimore County and is now in rehabilitation medicine.

Gerry Dobrzycki, MD Baltimore County Department of Health, has been elected to a two-year term on the board of directors of the American Cancer Society, Baltimore County.



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executive director's newsletter

January 1973

GOLDSTEIN FUND

The Faculty has assumed custody of the Albert E Goldstein Memorial Fund. Accumulated income from these funds was recently donated to the University of Maryland School of Medicine for use of Fellows in the Department of Urology.

Persons interested in the field of Urology and having worthwhile projects to be supported may submit requests for the funds to the Faculty office.

1973 DUES STATEMENTS

Dues statements for 1973 were placed in the mail to all members early in December 1972. Enclosed with the mailing is an appeal from the Faculty president for payment of all items included in the dues bill -- such as contributions to AMAERF, MMPAC.

Physicians are reminded that payment prior to Jan 31, 1973 is required in order to be eligible for legal defense of professional liability cases that may be entered against members.

An average of at least one case a day was reported to the Faculty office during 1972.

DUES AND MEMBERSHIP COMPARISONS

While inflation has been checked slightly on a national level, a recent comparison of state society dues and membership, state by state, reveals:

Average dues \$105.40; ranging from \$60 to \$200; with a median figure of \$100 and a mode of \$100. Maryland's matches these latter two -- \$100.

Membership size, nationally, is 4,272 on the average, with state societies ranging from a low of 319 to a high of 24,840 members. The median is 2,500 members. Maryland is slightly above the average, with 4,300 members.

Dues increases during the last several years by state societies show a range of \$5 to \$125. The median is \$25; and the mode is \$25, again with Maryland being in this area. The average increase was \$27.

RESOLUTIONS
FOR
ANNUAL
MEETING

Resolutions for the Annual Meeting must be received in the Faculty office before Friday, March 2, 1973, in order to be considered by the House. This is in accordance with Faculty Bylaws, Article XI, Section 26.

PSRO

PSRO is a term that will be heard frequently in the coming months. It stands for Professional Standards Review Organization. It is hoped the Maryland Foundation for Health Care will qualify before the end of 1973 as the PSRO for the entire state, or at least for a majority portion of the state.

Vested in PSRO by federal law is the authority for conduct of professional review of all aspects of health care delivery for Medicaid and Medicare recipients.

From time to time more will be heard in this connection.

MARYLAND
FOUNDATION
FOR
HEALTH
CARE

Officers of the Maryland Foundation for Health Care, elected at the October meeting of the Board are:

Manning W Alden MD, Chairman
Watson P Kime MD, Vice Chairman
Kenneth Cruze MD, Secretary-Treasurer

Dr Alden is from Annapolis; Dr Kime from Baltimore; and Dr Cruze from Silver Spring.

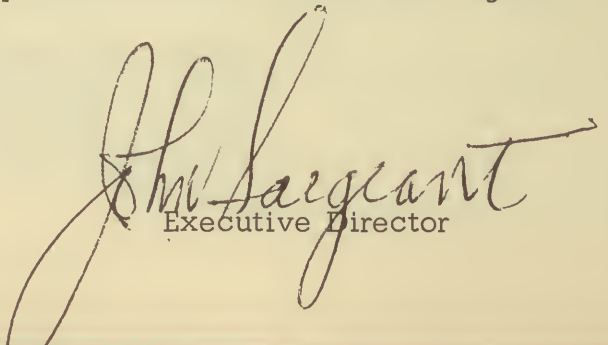
TRAVEL
PLANS

In the mail shortly after Jan 1, 1973 is information regarding the Faculty sponsored 14-day trip to Scandinavia, departing on May 31, 1973.

Reservations are also being accepted for the five-day trip to Mexico, which is part of the Semiannual 1973 meeting. Departure date is September 19. Contact the Faculty office for further details on these travel offers.

AMA COMMITTEE
ON
LONG-RANGE
PLANNING

The regional meeting of the AMA Committee on Long-Range Planning is set for Friday, Mar 9, 1973 at the Washington Hilton Hotel preceding the Public Affairs Workshop. Members may appear to present testimony in person or may submit written data in this regard.


Executive Director

CONCERNED

During these uncertain economic times?



Most professionals are concerned with the problem of putting their money to work where it will do the most good. Because of the many and complex vehicles that are available, it is difficult to choose the right combination of assets to achieve your financial goal. A financial plan must provide for many needs; such as savings, investment, retirement income, replacement income in the event of disability or death, education of children, and others.

There are Mutual Funds, Stocks, Bonds, Fixed and Variable Annuities, Life and Health Insurance, Savings Accounts, Various Banking Services, Pension Plans, Gas & Oil Shelters and many other programs. Some of these have been around a long time; others are relatively new.

Our company has developed a two-fold method of providing a most effective answer to your question, "How much and what kind of assets are necessary to fulfill the objectives

which I have established?" The first is F.A.C.T.S., TM* an electronic analysis system which will objectively view your assets and liabilities in light of your present circumstances and future ambitions. Secondly, an Advisory Committee will make recommendations which will enhance the success of your financial plan. The Advisory Committee consists of professionals expert in the areas of investment, tax-shelters, accounting, insurance, real estate, and related fields.

This service is provided on a fee basis, which is generally offset many times through the elimination of unnecessary expenses resulting from guesswork, high-pressure selling, and the lack of professional advice.

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American Association of Medical Assistants



Dr Lewison

Baltimore Chapter

Edward F Lewison MD, Baltimore surgeon, was guest speaker at the October 10 meeting at the Medical Examiner's Office in Baltimore.

Dr Lewison's topic, "Diseases of the Breast," was most informative and of great interest to all medical assistants.

He also showed the film on breast self-examination, prepared by the American Cancer Society. Citing the astounding statistics that from 5% to 7% of the female population will develop breast cancer, Dr Lewison said he could not emphasize too

strongly that breast self-examination is a must.

"Research for the cause of breast cancer is being carried on by several large hospitals; they are investigating the importance of family history (the chromosomal effect), viral transmission, and the hormonal problem," Dr Lewison stated.

He concluded that the big problem is to make the entire population aware that, at present, the best way to combat breast cancer is by early detection and that this is best accomplished by self-examination.

The most important item of business at the November meeting was the election of officers.

Mrs Jean Jacobson was honored by being named AAMA's Legislative Committee Chairman.

Wicomico Chapter

Bosses Night was held December 5. It was very successful; oysters and shrimp were enjoyed.

The assistants worked hard in the kitchen, making the

bake sale both luscious and profitable.

Anne Arundel Chapter

Mrs Betsy Franch was installed as President. Mrs Franch is deserving of this high office as she has worked above and beyond the call of duty to make this newest chapter successful.

The Banner

The Banner, official publication for Maryland, won an award at the national convention in Arizona.

Such awards are scarce and coveted. All in Maryland are most proud of all the assistants who have worked so hard to attain this honor for Maryland.

RITA CORBY, CMA
Publicity Chairman

•

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MRS. ROBERT A. REITER, Editor

woman's auxiliary

KEEPING AUXILIARIANS UP TO DATE

Many of our members who have not served on the State Auxiliary Board, and certainly most of our doctors, are unaware of the Fall Conference for State Auxiliary Presidents and Presidents-Elect and of the Regional Workshops for State Officers and Chairmen. These are held yearly in October and set the pattern for the winter's work. Though the title "workshops" sounds dry as dust, these meetings are, in fact, stimulating and productive of original ideas and worthy projects.

The Fall Conference meets annually in Chicago, where the state presidents and presidents-elect from all over the country gather to meet with the national officers. The conference is especially valuable to the presidents-elect who are thoroughly instructed in how to conduct meetings, parliamentary rules, the importance of Auxiliary projects, the need for relevancy in today's changing mores, and many practical ideas of what and how to do things.

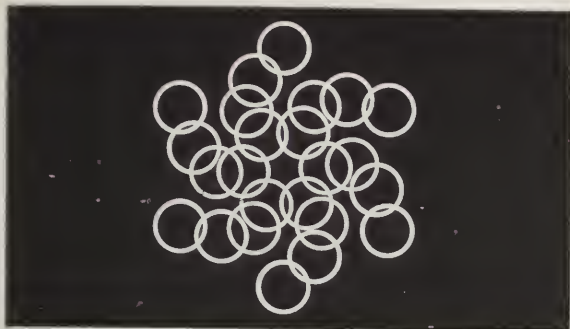
The Regional Workshops for State Officers and Chairmen are held yearly in October in each of the four geographical regions of the Auxiliary. The program is planned by the National Officers, according to general recommendations of the Board of Directors. Maryland is in the Eastern Region and this year's Eastern Regional Workshop was held in Cherry Hill, New Jersey, Oct 15-17.

The Fall Conference of 1972 for National Officers and State Presidents and Presidents-Elect was held October 8-10 at the Drake Hotel in Chicago. Projects stressed were the role of volunteers in nutrition service, safety on the streets, and a subjective approach to education. Auxiliary members were told that to insure success there needs to be enthusiasm in the communication of ideas, legitimacy, and showmanship; that in putting ideas to work, one must identify the audience, attract their attention, and keep the presentation short.

A featured speaker at the Fall Conference was John R Kernodle MD, Chairman of the AMA Board of Trustees. He issued three challenges to the Auxiliary: to organize membership campaigns, to strengthen the AMA's hand in Washington, and to expand the health education programs. Dr Kernodle said he asked the Auxiliary to help because, "it is as much your fight as it is ours and I believe you can strike some potent and effective blows in this, our common struggle."

Lessons in parliamentary procedure and courtesy are an important part of both the Fall Conference and the Regional Workshops. Mrs Herbert L Mantz, the well-versed parliamentarian who has charge of the courses, has five rules she considers a "must" for all presiding officers to observe: order, courtesy, justice, right of the minority to be heard, and the will of the majority to prevail. Further, she insists that all presiding officers must remember that power is invested in the office, not in the person presiding and that all rulings must be made only at meeting.

The sum total of all these meetings filtered down to local county chairmen on November 8, when State President Mrs Marvin Kolkin held a day of Workshops for county chairmen. Coming into the Med-Chi Building from all over the state, the county chairmen were briefed by Mrs Kolkin on the major subjects of the Fall Conference and Regional Workshops and given literature on the subjects prepared by the National Office. They then divided into their own study groups. Workshops particularly stressed this year were AMAERF, Community Health Education, Community Health Services, Health Manpower, and International Health Activities. In addition, a special conference was held for county presidents and presidents-elect. The Legislative Workshop was held in September at the Semiannual Meeting since the country's national presidential election was held November 7, the day before our regularly scheduled program.



From the Subcommittee on Alcoholism of the
Medical and Chirurgical Faculty of the State
of Maryland

alcoholism section

ALCOHOLISM AND THE FAMILY

SISTER DOROTHY KELLY (PSEUDONYM)
Teacher and Alcohol Counselor

Much has been written in recent years — especially by sociologists — concerning “families under stress.” Alcoholism, too, has received increased attention. And yet, very little has been written about the families of alcoholics. Often the discussion is limited to the family’s role in obtaining treatment for the symptom-bearer. Information is still somewhat limited on the effect of alcoholism on the family integration, on its interaction, on the roles of the family members, on the ongoing functions of the family.¹

Recently, Dr Earl Mitchell, cofounder of Melwood Farm, a rehabilitation center for alcoholics, told a group of clergymen: “Just to show you that I am not bright in some ways, I guess I went 13 or 14 years before I figured out what to do with the patient that won’t come in. Finally it dawned on me to say “Why don’t *you* come in? We will see what we can do working with you, the family.”

In writing about Alcoholism and the Family, I write as one who wears several hats — each of which, to some degree, has helped me to understand the subject a little better. In fact, it is because I wear these hats that I am grateful for the opportunity to share my thoughts with you. I teach in a small coed high school in Maryland. The size of the school lends itself to a rather close-knit spirit impossible in a larger institution. This, coupled with the fact that I teach many of the students for three out of their four years, facilitates my knowing them on a personal basis.

In her book, *The Forgotten Children*, Margaret Cork states that school mental health workers frequently find a startling correlation between a child’s adjustment problems and his parent’s alcoholism.² This has been verified in my own ex-

perience.

I see children sitting in front of me day after day who are virtually unable to concentrate because of family troubles. They have been constant witness to physical violence at home and are physically and emotionally drained by it. For this reason, when I ask them to reason through a math problem, they have no resources at hand. Often they have heard threats of parental separation, and the uncertainty of who will or will not be home when they get there causes further distraction.

The dulled state of the alcoholic, as well as his guilt-laden feelings make it impossible for him to establish meaningful, loving relationships with others. He is often so convinced of his own failure and lack of worth and so filled with self-disgust that he seeks confirmation of this hatred in others. Because of this, he perfects the art of provoking others to anger and projects this image of self-hatred to others. He is so preoccupied with self and dependency needs that he can’t reach out to anyone — even his children.³

Pain, tension, anxiety, and resentment increase in the family, especially in the spouse of the alcoholic. She or he begins to feel self-pity and to lose self-confidence as behavior fails to stabilize the other’s drinking. Children cannot turn to this parent for love and attention because anger, frustration, and futility make it nearly impossible for such a one to be of any comfort.¹

In an effort to gain attention and to win approval — at least from peers — a child may act out his frustrations in one or more ways. He may frequently become the class clown or the “know-it-all” who has a comment to make about any statement offered. If he is an average- or below-average student he may resort to cheating just to achieve high grades and appear successful. A girl may be inclined to become the “yes-man” of

teachers and friends. She may compromise for the sake of engendering herself and refuse to take stands for fear that she may not be acceptable. A recent study indicated that male children of alcoholics were assertive, rebellious, overtly hostile, with an over-emphasis on masculinity.⁴ Girls, on the other hand, tended to be self-defeating, vulnerable, pessimistic, and fluctuating in their moods.⁵

As incidents of excessive drinking multiply, social isolation of the family begins. This increasing isolation magnifies the importance of family interactions and events. "It also makes more desperate the child's need and desire to establish satisfying relationships outside the family. In this, he is handicapped. Being sensitive about his home situation, he lies about his parents or phantasizes about them to his peers." (Dr William Bosma) This prevents him from forming the close friendships so necessary to adolescents especially. Gradually, he isolates himself from others because he is afraid to tell anyone about his anxieties. He may, for a time, discover pity and seek compensation from it.

In reality, he needs love and understanding. This stage is very aptly described by a young woman in Alanon who was speaking about her teenage years. She said, "I became one of those I have to call 'turtle people'. I hid from the world in a shell I had created. I was careful — very careful — to let no one come into my life and let nothing of my life leak out — then I discovered a thing called pity. I found that if I told people about the assaults and batteries and the mortgage foreclosures, and things like that, they would pat me on the back and say 'Poor Mary Ellen, look what she is living with', and I liked it. It was a great way to get the attention that I wanted. So I kept it up. You see, I hurt. I still hurt. Even after being patted on the back. Any pity or sympathy they neglected to give me I gave myself. There were people who tried to help me. They offered me love, but I couldn't accept love because I correlated love with pain. I did not know what to do. I was confused. I didn't understand alcoholism; I didn't know it was a disease. I didn't even know that it was the alcohol that was causing our family problems."⁶

Within my role as teacher, I see the opportunity to be aware of children such as Mary Ellen and help them. I see the possibility, through my daily contacts with them of building up their self-image, of letting them know that I do love them and respect them for what they are in themselves. I need to let them know that I do understand them and that I am willing to invest time and effort in helping them. Hopefully, at

some point in our relationship, the child will have enough confidence in me to speak about his problem. Many of the students are aware of my work at the State Hospital, and this sometimes gives them an opening.

The very qualities which make possible a growth-producing family — tenderness, compassion, emotional maturity in parents — are in short supply or are early casualty of the illness of alcoholism. It is not surprising, therefore, that few, if any, children of alcoholics escape without emotional scars. Too often in the past, the anxieties and frustrations which cause these scars have been ignored. In a recent address to the American Medical Society on Alcoholism, Dr Willem Bosma stated, "The children of alcoholics are principals in a hidden tragedy." One would wonder how we can continue to close our eyes to them when statistics clearly show that over half of all alcoholics have an alcoholic parent⁸ and when we are led to believe that there is a high incidence of drug abuse and mental disturbance among the children of alcoholics.

In speaking at length, as I have concerning the effects of alcoholism on the children of alcoholics, I do not mean to minimize difficulty that the spouse finds in adjusting to this cumulative crisis. If I seem to be prejudiced in speaking of woman as the nonalcoholic spouse, I do not mean to be. It is only that in my work with families I have dealt most often with the male alcoholic. Also, the Alanon group which I attend is composed chiefly of women. I am keenly aware, though, as I am sure you are, that the number of known women alcoholics is rapidly increasing. I realize that if it is the mother who is alcoholic, the situation is even more desperate, as young children especially depend more on her for their physical and emotional needs. In regard to this, Howard Clinebell states, "In families where the father is the alcoholic and the mother has received help, damage can be minimized. Where the mother is the alcoholic, the damage is often deep."⁷

Joan K Jackson, in a booklet entitled *The adjustment of the Family to the Crisis of Alcoholism* speaks of the adjustment of the spouse as occurring in various stages. She states that all family members behave in a manner which they hope will resolve the crisis and permit a return to stability. Each member's action is influenced by his previous personality structure; by his previous role and status in the family; and by the history of the crisis and its effects on his personality, roles, and status up to that point. Action is also influenced by the past effectiveness of that particular action as a means of social control before

and during the crisis. The behavior of family members in each phase of the crisis contributes to the form which the following stages will assume and sets limits on possible behavior in subsequent stages. It is these stages, as seen in the spouse of the alcoholic and family, that I shall attempt to discuss, capsuling what has been discussed by this author.

Usually, at the time marriage was considered the drinking was somewhat limited. In some cases, alcoholism may be well in progress but it is hidden from the partner. It is true that certain types of women marry alcoholics in order to satisfy deep unconscious needs. Among these, three types are generally discussed. There are those people who need to suffer in order to find a sense of worth or value in life. They seem to thrive on bleeding emotionally. Often they use the alcoholic in order to suffer.

Some people are sadistic and need someone to punish. The alcoholic fulfills this need perfectly. In fact, it has been said that some of the meanest women in the world are married to alcoholics. Others like to control and dominate other people. The dependency needs of the alcoholic play right into the hands of the controlling wife. It should be noted here that these same characteristics may be found in parents, or brothers and sisters of the alcoholics.⁷

While we know that there are some wives who need alcoholic husbands or husbands who need alcoholic wives to gratify their own neurosis, it is generally safe to assume that the majority of those who enter marriage have no knowledge of the alcoholism or how to cope with it.¹

Somewhere within the marriage, incidents of excessive drinking begin; and, although these may be sporadic, the relationships between the spouses become strained. In an attempt to minimize these incidents, both husband and wife try to avoid discussing other difficulties in the marriage, thus creating the illusion of a good marriage. Episodes of inappropriate drinking mount. The wife worries about these and tries various trial and error methods to avoid them. She soon learns that none of these are permanently effective.

If she tries to approach friends about the problem she is usually told that her fears are exaggerated, that her husband can control his drinking. If she suggests to her husband that he cannot control his drinking, he reacts with resentment and rebelliousness. It becomes impossible to discuss it rationally.

All the while, the wife sees the inappropriate drinking as a threat to the family's reputation and status within the community. Invitations to

social events are becoming less frequent. Periods of socially acceptable drinking are becoming shorter. Discussions of the drinking are avoided by family and friends.

As the isolation increases, family members are thrown into closer contact with one another. As a family, they are cut off from supportive- and perspective-giving relationships at a time when they need them most. The more it turns in upon itself, the more its problems feed upon themselves and grow. The drinking behavior becomes the focus of anxiety and all interaction is centered around it. All family difficulties are attributed to it.¹

During this time, too, the wife makes more and more attempts to cover up. When the employer calls to inquire about the husband's absence from work, various excuses are given. She is afraid to face the consequences of lack of support in addition to her other worries. Children ask questions about their father and these are evaded. Feeling that the family must solve its own problems, she keeps the trouble to herself and will not seek outside help. Even if her husband beats her, she will bear it rather than call the police.

Love cannot continue to exist in this type of action and interaction. Husband and wife are drawing further apart. Each feels resentful of the behavior of the other. If this resentment is expressed, further drinking ensues. If it is not expressed, tension mounts. More harm is done to the family during the next drinking episode. Discussions are unproductive because the husband is more and more convinced that his wife cannot possibly understand him.

For her part, the wife feels increasingly inadequate. Because of social isolation, her sense of worth is bound up almost entirely with her roles as wife and mother. Each time she is unable to help her husband, her sense of adequacy as a person is lessened. Her guilt becomes one of her greatest problems and also one of her greatest hindrances in constructive relationships with her husband. Family efforts to control the drinking become desperate. In fact, all behavior is now oriented around it.

Still, there is an attempt to paint the "nice family" picture. When father is sober, the children are expected to respect him and obey him. When he is drinking, the wife tries to shield the children from the effects of his behavior. As she does this, she draws them closer to herself and gains much emotional support from them. During the sober periods, the husband tries to win them back again. Often, this pleasant interaction is the only direct interaction there is between father and children. Because of this, they may

feel much affection for him. This is another source of conflict for the wife. She feels that she needs and deserves the love and support of the children. Her own needs are not being met in the marriage. She may try to escape this loneliness by exploiting the children in an attempt to derive emotional satisfaction from them that she should be getting from the marriage. Still, she doesn't want to destroy the image the children have of their father.

It is at this point that self-pity on the part of the wife usually enters the picture, if it has not appeared before. In her mind, the husband should certainly see what "he is doing to her" and stop drinking. She is also aware of the attitude of others and seeks their praise and sympathy for what she is doing. In reality, she is expressing her contempt for her husband. There are fewer and fewer attempts to understand him. As hostility, resentment, and frustration mount, both husband and wife feel trapped in a situation they cannot tolerate. Still, they can see no way out of it. The wife's self-assurance is almost completely gone. As she compares herself with the person she was 20 years ago, she is frightened and worries about her normality. She is afraid to take action and afraid to let things remain as they are.

Usually, some crisis occurs which necessitates action. There may be no food in the house and no money in sight. Perhaps the husband has been violent to the children. Maybe it is just that life in general has become unbearable. At this point, some wives leave — either in fear or in anxiety.

Concerning this, Joseph Kellerman states, "If the wife leaves in fear, she will return in anxiety. If she leaves in anger, she will return in embarrassment and resentment."⁸ The wife who remains generally assumes the role of head of the house and manager of the family. She may feel that this control is an absolute necessity if the family is to survive, and it well may be at this point. As she takes over the family with some degree of success, the husband feels and becomes less and less necessary to the activity of the family. Perhaps this is why Kellerman says "Unless the wife (or mother) refuses to assume ultimate responsibility for managing the family situation, there is little chance that the alcoholic will assume it or his own role. While there is no absolute guarantee of a successful solution by a release of controls, the reverse is relatively certain." At this time, too, it becomes obvious to the husband that members of the family are able to enjoy themselves without him. He makes a desperate attempt to crash the circle either by warmth or by force. In either case, he cuts himself off.

The family seems to adjust to his drinking.

Before, the members suspected some connection between their actions and his drinking; they now accept the fact that father is unpredictable. In other ways, however, insecurities increase. Money comes into the home less regularly. Violence seems to increase when the father is at home. Often times he withdraws; while he is away, the wife worries about automobile accidents or self injury. The husband becomes quite ill from time to time and may require hospitalization. During these times he often expresses wishes to stop drinking. He may even venture into AA for a time.¹

In an attempt to stabilize things, the wife may be forced to approach some social agency. She may go to family court or seek legal advice about receiving a restraining order when her husband is particularly violent. From these outside sources, she begins to learn that her husband is ill. She also gains some perspective on her problem. She begins to realize that she must take a good look at her own involvement with the alcoholic before she can take steps to aid in his recovery. She sees that the change must begin with her if change in the alcoholic is to be anticipated. In speaking about this, Dr Mitchell said, "There is seldom an alcoholic that can't be helped if he has a family that is willing to invest, and he himself is ready to try to make it work. The patients that I can't help are the ones that are geared to some sort of sick relationship where nobody wants to change anything except the other person. A lot depends on getting the family to see their importance in helping the alcoholic. And, of course, the most important thing is for them to see what they can do for themselves. They must make their own life in the situation a more tolerable one."¹¹

"Knowledge of the nature of alcoholism as an illness and the courage to live by this knowledge are essential if fear is not to replace love in marriage. Unfortunately, many families suffer repeatedly from drinking and its consequences, thinking this is required if they love the alcoholic. The tragic result is that alcoholism is thereby perpetuated and fear and resentment take over human emotions."⁹

We, as helping people, must support the wife in her conviction of thinking of the family first. We must help her to see that if love is to be retained by family members, they must learn not to suffer when drinking is in process and to refuse to suffer to undo the consequences of drinking.

It is generally agreed that most alcoholics will seek help only when they "hit bottom." For a long time it was assumed that "bottom" had to be skid row or a cell in the county jail, but we

are gradually recognizing the fallacy in that concept. In speaking of this bottom Herman Krimmel, director of Cleveland Center on Alcoholism, said, "The bottom is different for each individual. It is that point at which he says to himself: 'I've had it. If this is what alcohol does to me, I'd better quit drinking'. Hitting bottom, then, is another way of saying that the alcoholic finally meets a crisis that makes him want to alter his behavior."¹⁰

A wife or mother may try to protect the alcoholic from such a crisis with the best of intentions. She should be helped to see that the alcoholic who is sheltered from the reality of his behavior has little reason to stop drinking. He continues to derive satisfaction from his drinking; he does not have to face the consequences of his drinking, so why should he stop. The alcoholic will not seek recovery as long as the alcoholic needs are met within the family. The family must offer the alcoholic love and understanding in his sobriety but not protect him from the pain or consequences of his drinking. This means suffering, but suffering with him in the pain of consequences, not by becoming the means of his escape from consequences. It may take real courage to suffer embarrassment, financial deprivation, loss of job, or, in some instances, temporary separation. It is possible for wife to leave her husband in love, rather than waiting for her love to be destroyed. Also, for some wives, attempting to continue living with a drinking alcoholic may be so destructive that continuation of marriage would result in irreparable damage to wife and children. Thus motivated by love of self, love of children, and still loving her husband, a wife may separate to protect self and children. If, however, she leaves in love, she may return at any point when conditions have sufficiently changed to make a genuine reconciliation possible.³

Joan Jackson briefly describes the next stage during which the wife and children reorganize without the husband. This may occur when there is actual physical separation. It may also occur when there is "divorce within a home." In either case, the family becomes reorganized.

The final stage is entitled "Recovery and Reorganization of the *Whole Family*." It is described as the period during which the husband achieves sobriety, the family reorganizes to include a sober father, and experiences problems in reinstating him in his former roles. Gradually, though, a wholesome readjustment occurs during this stage.

It should be noted that this happy ending does not necessarily follow. Joan Jackson could

include it because her study was done in an AA Wife's group. The movie "Country Girl" displays very vividly the manner in which each of the spouses in an alcoholic relationship fed the neurotic needs of the other. The alcoholic, being immature, craved mothering. The wife, having a dominant, protective personality, fell naturally into the mothering role. The more she accepted the responsibility for running the family, the more dependent and irresponsible he became, as well as resentful and alcoholic. The more irresponsible he became, the more she felt she had to manage everything for the family. Thus a vicious circle developed.⁷

Unfortunately, there are too many families in which this same, or similar, circle is self-perpetuated. There is little that can be done until some member is willing to take a stand and break the system. If people are comfortable in playing games with each other, we must grant this freedom. Recovery from alcoholism involves the healing of the emotional illness of all members of the family. If one sick person, though aware of the needs of another person, does not want to rock the boat, cannot let go of the other, then there isn't much an outsider can do.¹¹

In the process of recovery, even with the support of family, it is not possible to expect that all compulsive behavior disappear overnight. Also, it is wrong to assume that all problems in the family are entirely the effects of alcoholism. Inadequate marital adjustment can be the cause of drunkenness as well as the effect of it. In fact, sociologist Seldon D Bacon emphasizes the fact that the same kind of personality problems which tend to make one susceptible to alcoholism also give rise to marital discord.⁷

Even with those problems which appear to be the direct result of the sickness, we must expect it to take time. A new family system, which incorporates the alcoholic, must be established. This may be a real threat to the wife. While she realizes that reinstatement of her husband in his family roles is necessary to his sobriety, she is covetous of the control which has been hers. Her feelings about helping him regain his role as father are ambiguous. She feels resentful of his intrusion into a relationship she has worked hard to establish. She often feels left out as the children begin to turn to him. A resurgence of self-pity occurs. She may find herself capitalizing on the weaknesses of her husband in order to swing the children back toward herself. Above all, she is resentful of the fact that someone other than herself was able to achieve what she could not. She, too, needs time for adjustment and healing. She needs reassurance and constant reinforcement

that she is loved and respected for what she is and that she has self-worth and identity apart from her husband's sickness.¹

Alcoholism is a chronic disease — a disease that took a long time to develop. It has affected a lot of people besides the alcoholic. It takes time for change and for healing. I know this from personal experience.

At the outset, I wrote of the several hats which I wear. Up to this point, I have referred only to my teacher hat and my counselor hat. These have given me much experience, but all vicarious. I feel that my third hat has been the most valuable in my understanding of alcoholism — not only as a disease, but as a family disease. Having had a father who was able to recover from alcoholism only in the last years of his life, I am aware of the pain and confusion and ambiguity which are a part of the family of the alcoholic and, above all, a part of the alcoholic himself. I am aware of the feelings of futility and frustration which the family lives with during these years when things seem bleakest. The experience that I am having now with my sister who is fighting a battle with herself and recovery brings alive that same frustration at times.

Yet, I had the joy of seeing my father recover and of getting to know him as the beautiful, sensitive person he was. I feel that I can give hope to others who want hope and are willing to work and to change things.

My oldest brother was a problem drinker too. Three years ago, when he heard of my work at the State Hospital, he wrote to me. I quote a part of his letter:

"You say you are untrained — and to a degree that is so — but the key lies in letting the people know that you understand them — that, at least to a degree, you've been there. You see, you too suffered from alcoholism to the extent that we who drank in the family, influenced your life. Another way of saying it is that certainly your life was affected and you suffered as a result of our drinking.

"Remember too, that the families of these people need help and encouragement. Tell them that there is hope, — that you've got a brother in the USA who suffered from alcoholism who — through the grace of God — and the help of AA has not had a drink in 5½ years and who is much better off now in all respects than he ever was — even before he had a drinking problem." So ends my brother's letter, but not his encouragement.

Because of him and people like him, I believe that there is hope.

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Contraindications: Hypersensitivity to sulfonamides. Infants less than 2 months of age; pregnancy at term and during the nursing period.

Warnings: Safety in pregnancy not established. Do not use for group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported following hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indicators of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: **Blood dyscrasias:** Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia; **Allergic reactions:** Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, severe sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival scleral injection, photosensitization, arthralgia and allergic myocarditis; **Gastrointestinal reactions:** Nausea, vomiting, abdominal pains, hepatitis, diarrhea, enteritis, pancreatitis and stomatitis; **C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; **Miscellaneous reactions:** Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L.E. phenomenon have been cured. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides), oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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acute, recurrent or chronic nonobstructed cystitis

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*Koch-Weser, J., et al.: Arch. Intern. Med., 128:399, 1971.

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ROCHE



NEIL SOLOMON, MD, PhD, Secretary

Maryland State department of health and mental hygiene

THE PHYSICIAN AND THE ENVIRONMENT

HOWARD E CHANEY

Director, Environmental Health Administration
Maryland Department of Health and Mental Hygiene
and

ROBERT B MANCKE

Public Health Educator
Environmental Health Administration

The environment has been known for many centuries to play an important role in the quality of man's health. Hippocrates indicated in his writings that one of the fundamental basics of the practice of medicine is understanding the effects of environmental forces on man. Environmental forces included air, water, food, wind, land, and living habits. René Dubos has indicated that "... all manifestations of human disease are the consequences of the interplay between body, mind and environment."¹ This is not a new philosophy. It has been a significant part of the philosophy applied in public health practice. Naturally, the identification of individual environmental problems and their relationship to health evolved over a long period of time and on a "piecemeal" basis.

One of the effects of man's incompatibility with his environment is the occurrence of diseases. Studies of remains of animals and human beings have revealed that health may be readily achieved after a particular specie has spent many generations in an unchanging and stable environment.² The occurrence of sickle cell anemia trait is an example of the adaptive process to maintain compatibility in a stable malaria-ridden environment.

In industrialized nations, the environment is constantly changing as a result of man's technological development. This can be seen in the increase of population, the foreign chemicals added to the air and water, the replacement of flora with petroleum products such as asphalt,

etc. Because the balance maintained within an environment is very delicate, any change may upset this balance. The recent occurrence of *Gonyaulax tamarensis*, or red tide, off the coast of New England was attributed to an extensive dredging operation which increased nutrient levels in the water. This resulted in a number of illnesses among the coastal population who ate the contaminated shellfish. Likewise, changes within the environment may cause immediate or delayed physiological disturbances affecting man's well-being.

Alfred Grotjah identified the following propositions regarding the environment and disease causation. The environment:

- ... "(a) may create or favor a predisposition for a disease; (b) may themselves cause disease directly; (c) may transmit the causes of disease; and (d) may influence the course of a disease."

In an attempt to reduce environmental factors which influence the prevalence of all diseases and maladies, the Environmental Health Administration of the Maryland State Department of Health and Mental Hygiene has been given the authority to control these conditions. However, strides in this area have been attributed to recent efforts which include long-range environmental planning, investigative and control programs, and the multiplicity of routine procedures conducted by public health environmentalists.

Presently, the Environmental Health Administration is divided into three bureaus: the Bureau of Air Quality Control, the Bureau of Community Health Protection, and the Bureau of Consumer Health Protection. The primary operational objective of the Environmental Health

Administration is to assure that all environmental conditions deleterious to health are prevented or controlled. To accomplish this objective requires that the medical community be aware of the services and programs provided by the Environmental Health Administration which can assist the practitioner in the diagnosis and treatment of disease.

Medical and scientific findings have indicated that air pollution may be a significant factor in many serious diseases and premature deaths. It increases the difficulty of sustaining life among persons who suffer from heart and respiratory diseases.

Using criteria such as health effects induced by the presence of pollutants in the air for setting Maryland's air quality control regulations, air quality has sharply improved. However, this does not preclude that no problem exists. The build-up of pollutants in specific areas is dependent upon the weather conditions.

The Bureau of Community Health Protection is responsible for overseeing that human, animal, and solid wastes are disposed of in a sanitary manner and that waters designated for drinking, shellfish, or bathing meet basic health standards.

Political subdivisions of the State submit 10-year water and sewerage plans to the Administration to review for adequacy and to process their applications for Federal and State construction grants. This assistance is helpful in maintaining continuity of planned community expansion. This is also required for solid waste management.

Another important function is the bacteriological surveying of waters from which shellfish are harvested, as well as the testing of public beaches and swimming pools.

State standards for the sale of milk and various foods through stores, dairies, restaurants, and other retail and wholesale outlets are enforced through the Bureau's Divisions of Food Control and Milk Control. Milk control activities of the Baltimore City Health Department have recently been consolidated with those of the Environmental Health Administration in order to conduct a more unified program.

Recently, the Administration, in cooperation with the Department's Laboratory and Research Administration and the Public Health Service, identified that vibrio parahaemolyticus was responsible for several recent food-borne outbreaks attributed to crab feasts. Cooked crabs were contaminated as a result of poor handling. Now, the Department is beginning an educational campaign to improve handling practices to reduce incidences of this food-borne disease.

In making its services available to the physician, the Division of Drug Control assist the physician in identifying foreign-made or unusual drugs. From this Division, the physician will receive the generic make-up of the drugs and a bibliographical listing to direct the physician to literature regarding the drug in question. Under the State's Controlled Dangerous Substance Act, the Department licenses physicians who distribute them. This is done to prevent the indiscriminate distribution of drugs.

Protection of the public against the health risks of adulterated, misbranded, substituted, or sub-standard drugs is a major responsibility of the Division of Drug Control. Important activities include periodic audits of the drug purchasing and dispensing records of pharmacies, drug manufacturers, distributors of prescription drugs, general and special hospitals, nursing homes, clinics, importers, exporters, researchers, brokers, physicians, dentists, and veterinarians.

Also reviewed is the legitimate handling of hallucinogenic drugs, barbiturates, amphetamines, and narcotics in order to be sure that they are not reaching illicit street drug traffic.

Because of the complex nature of drug control activities, close liaison is maintained with the Maryland State Board of Pharmacy and other local, State and Federal agencies and professional groups.

This close liaison has effected the passage of significant legislation. One example is that prescriptions for drugs remaining for 30 days or more become invalid.

Recognizing that the use of radiation is increasing and that it is useful in medical therapy as well as energy production, the Division of Radiation Control works to minimize the unnecessary exposure of individuals to ionizing and nonionizing radiation from all controllable sources. To accomplish this objective, the Division has been approved by the Atomic Energy Commission and has accepted the authority to license and inspect users of certain radioactive materials.

An extensive radiation monitoring program is being conducted in order to control radioactivity which could be hazardous to public health. All radiation sources are inspected regularly by radiological specialists, and the program has been broadened to include checking of microwave ovens and high-voltage television sets.

As recently as the past century, diseases caused by man's working environment were so common that writers of the era coined some health related quips which are commonplace in our language today. For instance, when we jest that

someone is "mad as a hatter," probably few are aware that William Thackeray, Lewis Carroll, and others used the term to compare some fictional character's behavior with that of nineteenth century felt hat workers who frequently developed nervous and physical disorders from constant exposure to mercury used in hat manufacturing. Such problems of the occupational environment also are among those now being relieved through State and Federal regulations and the cooperation of business and industry.

Industrial hygiene specialists cooperate with industry in the correction and prevention of health risks in the occupational environment. They assist in the development of programs to prevent inhalation of toxic airborne contaminants, such as dusts, fumes, and gases; exposure to excessive noise, heat, or humidity; and other harmful effects of the general working environment on employees' health. Application of new knowledge and technique has made possible considerable control over such occupational illnesses as mercury poisoning, silicosis, and other respiratory diseases.

Some medical authorities believe that continuous exposure to excessive noise can cause hearing loss, migraine headaches, fevers, ulcers, persistent tensions, mental confusion, and may contribute to high blood pressure and heart attacks.

The Administration hopes that eventually it will be able to expand its noise-control program in order to determine the sources and degrees of noises which are injurious to health and what regulations may need to be developed to alleviate the problem. General community noise also is an emerging public health problem which must be controlled in order to prevent widespread hearing loss.

Maryland is making intensive and coordinated efforts to improve nursing homes. Part of the multi-pronged approach is a recently instituted regulatory program, which staff members of the Institutional Sanitation unit are participating in. They provide technical support and coordination of the stepped-up inspection activities and cooperate with local health departments in their inspection programs.

State and local sanitarians are responsible for enforcing laws and regulations related to such environmental health factors as water supply, plumbing, wastes disposal, sewage disposal, food areas, laundry and linen handling, general cleanliness, and accident prevention.

The same types of inspections are conducted in State-licensed hospitals, care homes, domiciliary homes, child care centers, and correctional

institutions. Although the physical facilities are the primary target, many of these responsibilities are related to patient care.

Although the Department can be proud of the degree of overall success which the Environmental Health Administration has experienced in controlling factors influencing the health of Marylanders, part of this success must be attributed to the medical community. Without the cooperation and long-range planning done by health and medical related organizations and professionals, progress may be virtually impossible.

Improving environmental conditions as a means for achieving optimal health requires the participation by the physician. After all, he is the most respected source of health information. In light of this, it is pertinent that the physician remains aware of the environmental and consumer health problems most prevalent in his community. This information can be obtained through the local and State health departments. Also, both the State and local departments are dependent upon the accurate reporting of maladies. This serves as indicators for problems which may be emerging and remain unnoticed by the Health Department personnel. After all, the presence of a disease is a symptom of a problem which remains unchecked. The constant open exchange of information between the health department and the physician can improve the effectiveness of all efforts to improve health.

The physician should be prepared for periodic adverse environmental conditions. An example is the air pollution alerts constantly menacing urban areas. The physician should advise his patients suffering from heart disease or respiratory diseases about precautions to be taken during an alert. In fact, the physician is an educator. The patient who is in the presence of a physician is experiencing a high level of concern for his personal health. It is this opportunity the physician should take in advising patients about existing environmental problems which can affect health along with necessary precautions. Education is one approach to preventive medicine. A physician aware of environmental conditions can extend these concerns to his patients.

Many diseases influenced by environmental factors are chronic and physiological in nature. Thus, they are closely related to the behavioral patterns of people. It will be the physician who can contribute toward his patients developing positive living patterns.

References

1. Dubos R: *Man, Medicine, and Environment*. New York: The New American Library Inc, 1969, p 90.
2. Ibid: p 92.

"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

**Are combination drug
products useful in treatment
involving concomitant use
of two or more drugs?**

Opinion

**Results of a questionnaire to
7,000 physicians:**

62.9%

**Believe combination drug
products are useful.**

13.8%

**Do not believe combination drug
products are useful.**

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in use for a number of years and that have an apparently satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I'm thinking particularly of penicillin-streptomycin combinations that patients—especially surgical patients—were given in injection. This made less discomfort for the patient, less demand on nurses' time, and few opportunities for dosage errors. To take such preparation off the market doesn't seem to be good medicine, unless actual usage showed a great deal of harm from the injection (rather than the preparation) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it could avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence and in making the ultimate decision.

Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of pedantry, the "expert" denies the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the rarest of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the usual dose being 650 mg.

The other semantic ploy often called into play is to describe a combination product as rational or irrational.

Take antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

What is your opinion, doctor?

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PEER REVIEW: PROBLEMS AND POTENTIALS*

OTTO C PAGE MD

President, American Society of Internal Medicine

Associate Clinical Professor of Medicine

University of Oregon Medical School

PANEL DISCUSSION ON PEER REVIEW

Moderated by

ARTHUR E COCCO MD

Chairman, Peer Review Committee

and participated in by Peer Review Committee members:

JOHN R DAVIS MD

LEEDS E KATZEN MD

WATSON P KIME MD

HARRY F KLINEFELTER MD

JOHN G WISWELL MD

**J M T Finney Fund Lecture and panel discussion, as edited, 174th Annual Med-Chi Meeting, Civic Center, Baltimore, May 3, 1972.*

Introductory Remarks

By Dr Cocco

Members of the Med-Chi Peer Review Committee welcome the opportunity to present this program.

To some, peer review has been accepted with enthusiasm; to many, it has been tolerated with reservations; to a few, it has been met with disgust and hostility. These sentiments are probably healthy, because from such dialogue undoubtedly will come a program which will benefit and improve health care.

Your Peer Review Committee has functioned for the past two years; without exception, members have worked long and hard. There have been occasional disagreements; at times, overt arguments; but, without exception, committee members believe in peer review and have given unselfishly of their time and efforts to develop a working organization.

Hopefully, at the end of today's program we will be a little closer to a better understanding of the problems confronting all of us and to the concept of peer review.

The fact that a national health insurance program will probably evolve in the not-too-distant future makes it imperative that we are not left on the sidelines bickering with petty, meaningless

dialogue while society goes about its inevitable changes. Most of us agree that legislative changes are inevitable and that increased expenditures to finance these changes must follow.

The present proposed legislation recognizes the practicing physician as being in a much more secure position than his academic colleague, since most health care bills overlook the areas of education and research.

The premise that doctors should be reviewed by doctors—whether in the academic, research, or clinical context—is identical to the philosophy of your Peer Review Committee. To go even further, we have instituted a mechanism to involve specialty societies, where applicable. Referrals are also made to component societies to perform peer review at the local level. We have attempted to establish districts of peer review throughout Maryland on a basis of physician/population ratio. The State Peer Review Committee is well aware that problems in medicine differ from one region to another. For this reason, it was felt that local peer review groups will do a better job of evaluating and solving problems endemic to their area.

We are honored today to be able to present Dr Otto Page who will give the J M T Finney Fund Lecture.



PEER REVIEW—Guest speaker Otto C Page MD (right) answers an audience question. Moderator Arthur E Cocco MD is at the lectern. Panelists, L to

R, are Drs John R Davis, John G Wiswell, Harry F Klinefelter, Katherine H Borkovich, Watson P Kime, and Leeds E Katzen.

Lecture by Dr Page

We are living in a time of rapid change affecting not only medicine but all of society. It is my opinion that no one really likes the new—we're afraid of it. Even in slight things, the experience of the new is rarely without some stirring of foreboding. In the case of drastic change, the uneasiness is, of course, deeper and more lasting. We can never be really prepared for that which is wholly new. We have to adjust ourselves and every radical readjustment is a crisis in self-esteem.

The principle of peer review is not the radically new concept that some would have us believe. For many years the medical profession has accepted the concept that the individual physician's performance is subject to review by his peers. Such review has been performed in hospitals by credential committees, tissue committees, racket committees, and at mortality and morbidity conferences. What is new is the extension of peer review to medical care wherever provided and the profession's corporate accountability to the public for the cost and quality of medical care. The issue facing medicine is the interrelationship between the quality of services provided, the quantity of services provided, and the cost of such services. And only the practicing physician knows how inextricably these three issues are interrelated and therefore cannot be treated as separate issues. The climate related to these issues can be summarized as follows: 1) the public questioning the availability and the cost of medical care; 2) third parties, including the federal government, concerned primarily with cost and utilization, and 3) organized consumer groups demanding controls to moderate costs.

The dilemma that faces medicine is how to maintain and improve quality while assuring efficient and economical delivery of expanded

services. As McGraw has pointed out, the fact is that in negotiations between the profession and the paying public, the public assumes that good medicine will be present, guaranteed and unchanging, and it is not a subject of negotiation or even an issue.

The necessity for comprehensive peer review can be briefly summarized as follows:

First, the medical profession at its best has traditionally assumed responsibility for the quality of care provided to the public.

Second, as the cost of medical care rises, such care wherever provided will be increasingly subject to review.

Third, only physicians understand that quality cannot be assumed and that rigid and ill-advised attempts to limit utilization and increase quantity can have an adverse effect on quality.

Peer review services outside the hospital have been, and to some extent still are, primarily a utilization claims review process initiated by the patient or a third party. These review organizations still function largely as a grievance committee. The foundation plans pioneered on the use of computers are developing patient and physician profiles as a means of recognizing aberrant patterns of practice or utilization. To the extent that improper utilization goes hand in hand with poor quality, utilization and claims review has the potential for a beneficial effect on quality. However, we must admit that up to this point in time audits for quality and ensuing action to improve quality through education or other measures have been an indirect spin-off from claims and utilization review.

Realizing that more effective methods for quality audit are needed, ISMA, the national center, has financed experimental projects for improving the quality audit. One of these is the contract of the American Society of Internal Medicine to

devise means of measuring office quality. A second approach has been to finance experimental projects with county and state foundations to develop computerized methods for quality audit, the so-called EMCRO program.

The initial approach of the Utah EMCRO group has been to try to find for each disease category the most common errors of omission or commission, and then they hope to program the computer to flag cases where these errors have occurred.

The Multnomah County Foundation EMCRO program, approaching the problem from the other way around, has set up prospective standards for diagnosis and management of the 20 most common diseases. A volunteer group of physicians will have their office personnel check their records against the predetermined standards. It is hoped that in the process they will find a few key items relating to each of the 20 diagnoses and program the computer to pick out claims where these key items appear or do not appear.

The claim form generated by physician-patient encounter will have the following information for use in peer review:

First, diagnosis accorded to HICDA or ICDA; second, services and procedures accorded with CPT; and, third, charges.

A key piece of information not included in the EMCRO program so far being developed is the problem with which the patient presents himself. Patients come to physicians with problems, not diagnoses, and an important function of the physician is to arrive at the final diagnosis, starting with the presenting complaint.

Adding to the problem in this case, one can see some justification for the services provided and procedures ordered. How can problem-oriented information generated by physician-patient contacts be used for educational peer review?

If Dr Brown submits a claim for a case of chest pain, this might be allowed occasionally, assuming these are unusually difficult diagnostic problems. If, on the other hand, it is apparent that Dr Brown orders all of these studies on every case of chest pain then Dr Brown needs some education and is sent the following letter:

"Dear Dr Brown: The cost of procedures and services generated by you for the presenting complaint of chest pain exceeds the median for Nassau County by 100%. Enclosed is a reprint from the *New England Journal of Medicine* on the differential diagnosis of chest pain. We believe this will be helpful to you in making a differential diagnosis without resort to excessive use of services and/or procedures. Sincerely yours, Your friendly and helpful peer review computer."

By comparing the frequency of diagnosis for a given complaint by a single physician with the frequency of diagnosis in established clinics or the norm for a county, further information for educational peer review could be developed.

Computer printout demonstrates that Dr Brown is misdiagnosing chest wall pain as angina or pleurisy, attributing pain to asymptomatic hiatal hernias, and is badly in need of education. It also suggests that many of the physicians in Nassau County also need some education in this area. Dr Brown received the following letter:

"Enclosed is a printout of the frequency of diagnosis reached by you with the presenting complaint of chest pain compared to the frequency of diagnosis reached by the great Midwest Clinic for the same complaint. Also enclosed is a reprint from *JAMA* which discusses in detail the differential diagnosis of chest pain."

Up to this point, we have discussed only the elements of the patient-physician interreaction, these elements to be related to each other in several ways.

Each component can be compared to the others; for example, facility compared to patient-physician, allied health personnel, insurers, cost.

The elements of care could be correlated with the components; for example, physician correlated with problems, diagnosis, procedures, services, and charges.

The elements could be separated by components; for example, the diagnosis could be separated by patient, physician, facility, allied health personnel, and insurer.

A profile is derived when a single element or component is compared to its other elements or components; for example, a physician related to problems, diagnoses, services, and charges.

A pattern emerges when groups within a single category of elements or components are compared; for example, patients related to diagnoses, services, and procedures.

Facilities to be categorized as all-hospital, ECF, nursing. Possibly they may be categorized as university, nonuniversity, teaching, community hospitals, or proprietary hospitals.

Insurers can be categorized all-location, financing mechanism, or payment mode.

The advantages of such an in-depth process may be summarized as follows:

- 1) Complete data regarding the spectrum of problems, diagnoses, professional services, procedures, and charges within a geographic area.
- 2) Compilation of information on all components of the delivery system.
- 3) Delineation of equation of care by a single

event or by totals with a reasonable handle on the quality of care.

4) Evolution of patterns or norms of acceptable practice for geographic location.

5) A method of identification of under—as well as over—utilization of medical care.

6) A system organized, operated, supervised, and interpreted by organized medicine focused on the quality of care as well as the cost of the product.

7) Provide a system to identify specific areas of deficiency in any component of the medical care system functioning to increase the quality and efficiency by educational or other appropriate programs.

The disadvantages of such a broad data base are obviously the volume of data for acquisition, storage, correlation, and retrieval for interpretation. Programing or the appropriate parameters for decision should allow computer assistance in handling and display of information.

Finally, a few words regarding medical records and peer review.

Warner Slack has observed that committing a piece of information to the average clinical record is almost the equivalent of throwing the information in the wastepaper basket. It becomes readily apparent that restructuring clinical records is necessary if we are to conduct a meaningful audit in depth and uncover anything more than the grossest of errors in judgment and treatment.

The first question of in-depth audit must be: Is the data base adequate? If it is not, further medical audit for quality is speculative at best. One does not want to be in a position of criticizing one physician for mismanaging a problem when he at least bothered to find it, while another physician gets off scot-free because he never found the problem and never recorded it and therefore cannot be criticized for mismanagement. If the data base is adequate, the next question is the proper identification of problems from the data base. The third question is whether the plan to arrive at a definitive diagnosis is relevant and appropriately identified; and, finally, the question as to whether the plan for treatment is appropriate to the diagnosis.

Bogdonoff, in an editorial in the *Archives of Internal Medicine*, states, "The WEED system provides us with a way in which to organize our thoughts so we can more effectively organize our care and research pursuits. This is so commonsensical and patently necessary that there can hardly be any further argument about the scientific value of the WEED system. Second is the ability of the profession to provide a monitoring and auditing of medical care that will permit

continuous surveillance of medical practice. The WEED system allows for assessment of the scientific bases for clinical decisions and therefore reexamination and recertification of the practicing physician."

I quote briefly from the American Society of Internal Medicine's Documentation Committee report: "Patterns of practice have altered significantly over the past 25 years from a time when the patient relied almost solely on one physician for care and the records served as a communication for the physician only with himself. The patient now relates to many physicians; he may receive care at multiple sites; he is apt to change his place of residence many times; and support personnel are becoming increasingly involved in his care. The present medical record can no longer effectively channel the communication necessary for present-day patient care. What is needed is a commitment by the membership to a process of documentation of care that will bring about attainment of these goals and objectives, and that review of performance made meaningful by this process of documentation be expected and welcomed as insurance for the patient and as a means of education and continuous upgrading of performance. ASIM could then further commit its organization, energy, and expertise to development of a system of certification by performance within well-defined limits based upon meaningful data of peer review, thus negating the need for reexamination and relicensure."

In summary, the medical profession has long accepted the principle of peer review. This has been accepted in the function of its hospital staffs. Extension of peer review to out-of-hospital medical care is a legitimate and necessary concern for the medical profession.

Present peer review for quality is largely a spin-off from utilization and claims review. Computer programs for quality control are possible. One approach, relating problems to cost and relating problems to frequency of diagnosis, has been discussed. With experimentation, other approaches will become apparent.

Comprehensive peer review would need a wide data base including information on all the components of the medical care delivery system and financing mechanisms. Universal acceptance of the problem-oriented record will increase the feasibility of in-depth audit for quality and provide a system for recertification by performance rather than reexamination or relicensure.

In *Future Shock* Toffler states that the problem is not to prevent change—which cannot be done—but to manage change. To manage change we must accept its inevitability and try to predict its

nature. To the extent that our profession can, despite uneasiness, accept and manage change, to this extent will our profession retain control of its own destiny. To the extent we fail to meet the challenge of change, our profession will be managed from without.

QUESTIONS

Dr Cocco: I'd like to ask a question, Dr Page. Where do you think the motivation for computer programs should arise? Second, who will provide the economic resources necessary to conduct or at least begin such programs?

Dr Page: I think a computer program for comprehensive peer review would be very costly, very complicated, and I don't think one should be started by a component medical society. Ideally, I think, this should be a function of the AMA to develop the basic software with perhaps local modification to meet local needs.

Dr Cocco: So, then with regard to the economic aspects, it would almost require some government involvement at a national level. Is that what you're saying?

Dr Page: I'm not too sure. It might require government involvement. I'm not too sure that the AMA working with the voluntary health plans couldn't do this if they wanted to. I think they could finance it between themselves and commercial plans.

Dr Cocco: The membership in part is probably aware that the Peer Review Committee recognized at the onset that audit, as well as standards, was needed and felt that some form of data-collecting system would be necessary. The foundation concept for data collection is being explored.

Dr Borkovich: Would you say a word about patient profiles?

Dr Page: Patient profiles, of course, are an integral part of the San Joaquin computer program. This uncovers the patient who goes to three different doctors in the same year for a complete workup and extra chest X-rays and EKGs. It's just as important to have patient profiles to control utilization as it is to have physician profiles.

Dr Cocco: I think that this particular aspect of audit has not been generally explored by many carriers in our area. I'm sure that most of us can go to almost any accident room in the city and recognize faces that are habitually there or perhaps had been seen in two or three other hospitals that same day or that same week.

Peer Review Panel Discussion

Dr Cocco: We plan to present three cases



PEER REVIEWERS—Drs Arthur E Cocco (at lectern) and Otto C Page field another audience question.

which were reviewed by the Peer Review Committee. Some of the ensuing dialogue and decisions are included. These cases are representative of problems confronting peer review committees.

The Peer Review Committee is presently referring many cases to the local groups. As mentioned previously, Maryland has been divided into districts. We have urged each district to formulate a peer review mechanism to hear and examine problems at the local level. Some areas have been enthusiastic and have approached the problem in an exemplary fashion, while other areas have done little or nothing. As you listen to these problems, each of you will agree that action is necessary and that it is probably much better handled by people in the local area when confronted with similar situations.

Referrals to the Peer Review Committee are submitted by third-party payers, physicians, patients, and the State Health Department. As time goes on, more and more channels of referral will be opened. The three cases presented here have been referred by insurance carriers.

CASE #1

The first case will be presented by Drs John Wiswell and Watson Kime.

Dr Kime: The third-party carrier has submitted 15 cases treated by the same doctor during a two-year period and reports there seems to be a pattern of practice not usual and customary according to their own utilization review standards. Most of the patients appear to be in the older age group, living in the same apartment complex in which the doctor has his office. I have examined them in detail. They appear to be very similar in the type of patient and the manner in which they are handled.

The first case concerns a 65-year-old female whom the doctor first saw on a home visit in December 1968. He saw her at home three times in a two-week period; gave her injections of Vitamin B12 and Vitamin B1; drew blood for a CBC, cholesterol, uric acid, and PBI. The diagnoses submitted as a result of these visits were hiatus hernia and late syphilis.

We have to presume that some of these diagnoses were substantiated by the patient's history as there were no X-rays or laboratory work to support some of them.

Dr Wiswell: I agree. Certainly, the diagnosis of hiatus hernia and late latent syphilis can't very well be made on the basis of the laboratory work performed here. Parenteral Vitamin B1 is only used these days for acute alcoholic encephalopathy. Vitamin B12 is for pernicious anemia, and there is no evidence for this diagnosis.

Dr Kime: The cause of the bone marrow depression has not been investigated. If we follow the case, we find that he saw her in his office on January 15, gave her an injection of Compazine. His diagnosis: jaundice and cirrhosis. Compazine may itself cause jaundice and should be used with caution in the presence of cirrhosis. He saw her again the following day (January 16) at which time he did a urinalysis, another complete blood count, and gave her an injection of Lincocin.

Why did he give her Lincocin? It was my understanding that Lincocin causes leukopenia, neutropenia, thrombocytopenia, and that its use in liver disease is not recommended. And yet his diagnoses are leukopenia, neutropenia, thrombocytopenia, and liver cirrhosis.

Dr Wiswell: That's right. Lincocin is a potent antibiotic for gram positive infection. It should not be used for viral upper respiratory infections; furthermore, the field may be opened for invasion by gram negative bacteria. There is no record of any cultures being obtained.

Dr Kime: I notice on the 23rd and 28th of January and on the 4th and 18th of February the patient visited his office and received injections as listed here.

The only change in the record is that the doctor has changed the priorities of the clinical diagnoses. On March 4, 6, 13, and 27, the patient visited the office and had injections of Lincocin, Talwin, Vitamin B12. In fact, we can document visits on April 8, 17, 24, and 28; May 22; and June 5, 19, 24, and 26. On each occasion the patient is rotated through a sequence of injections of Lincocin, Vitamin B12, Talwin, Vistral, etc, etc, etc. Do all of these drugs have to be given by injection?

Dr Wiswell: Certainly not, except for Vitamin B12; and I have already mentioned there is no indication for this therapy. There is no suggestion that the patient was too sick to take oral medication.

Dr Kime: Well, between June 26 and October 13, the patient either was not sick for four months or didn't visit this doctor because she was seeing someone else. On October 13 the diagnosis and treatment are as shown on this slide.

Dr Wiswell: I note that he also saw her on October 14 and 21 at office visits and gave her injections of Lincocin; but she returns on October 23 and now the diagnosis is a large hematoma, which was incised and drained.

Dr Kime: It strikes me that it's ten days from the time he restarted Lincocin to the time this patient appears with a large hematoma. Do you think that she might have had an allergic reaction to Lincocin with thrombocytopenia presenting as a hematoma?

Dr Wiswell: That is quite possible. Again, the cause of her thrombocytopenia has not been investigated or treated.

Dr Kime: Between Nov 11, 1969 and July 23, 1970, she sees the doctor 18 times. At each visit to the office she receives an injection of a medication or laboratory work is done. The laboratory work consists of all or any of the following tests: complete blood count, BUN, cholesterol, uric acid, urinalysis.

During this time the diagnoses submitted to the third-party carrier includes the phrase "rule out diabetes"; but at no time is a blood sugar ordered. On July 30, 1970 the diagnoses of acute bronchial asthma and arthritis appear with seven other diagnoses, of which the major complaint is "very upset" and the patient is given an injection of Depo-Medrol.

Dr Wiswell: I know Cortisone derivatives are used in the treatment of asthma and sometimes in arthritis; but is it usual and customary to initiate this with an injection of Depo-Medrol?

Dr Kime: No, I don't think so. Except for status asthmaticus, which may require intravenous Hydrocortisone, asthma or arthritis can be managed with oral Prednisone if there is not a satisfactory response to the usual other medications.

Dr Wiswell: I think that the handling of this case indicates an unusual pattern of practice. It appears that this physician treated symptoms and signs without attempting to establish diagnoses. I believe we should ask the doctor to bring his office records on these patients and discuss the handling of these particular patients with the entire committee.

Dr Kime: I agree with you 100%. We have only been working with computer-generated financial data and the doctor's listed diagnoses. But it is possible to reconstruct fairly accurately a pattern of practice exhibited by this physician.

Dr Cocco: This is in line with our own belief concerning peer review. We are not primarily concerned with the costs of medical service. We are concerned in the main with the quality of medical care.

But time and time again we have seen that where the costs of medical care are out of line with that which is usual and customary, the pattern of practice and the quality of medical care is also out of line with that which we consider usual and customary.

CASE #2

Dr Cocco: The next case will be presented by Drs Katherine Borkovich and Harry Klinefelter.

Dr Borkovich: The physician whose practice I wish to discuss briefly with you came to the attention of what was at that time a liaison committee between Med-Chi and our Maryland intermediary for Medicare, ie, the Blue Shield organization.

Both of the gentlemen are in the audience who had initially visited this board-certified internist's office to ascertain the office set-up and to personally discuss it with him. The subject matter was then referred to the committee, the precursor of the Peer Review Committee. He was informed that the reason for the visit was because it had been noted that his utilization profile was quite different from that of other specialists in internal medicine in that community.

We had this material turned over to the special liaison committee. In the next few slides I wish to exemplify two cases which really represent almost the entire volume of this physician's Medicare practice.

As you see, the diagnosis of arteriosclerotic cardiovascular disease and coronary insufficiency are listed. What had been noted by the carrier was that this physician's practice was to have the patient have initial complete work-up, a tremendous amount of laboratory data initially, and again about 11 or 12 months' later; and, at monthly intervals, patients were being seen, at which time an electrocardiogram, chest X-ray, and significant laboratory work were usually repeated.

From the financial information here, I believe one can see the amount of expense involved in the laboratory requests that were made for the care of these patients. In this particular patient, this amounted to about 60% of the total cost.

The next slide shows a similar case and, as you can see, the proportion of laboratory charges amounted to 70% of the total charges. This is just an example of some of the laboratory studies that were being ordered. Once a year between \$90 and \$120 worth of laboratory studies were ordered, and then at monthly intervals anywhere from \$15 to \$30 worth.

Now, sampling 24 cases, you see the breakdown of percentage of charges for services rendered.

The physician was asked to appear before the regional liaison committee to discuss with us his manner of practice, and to justify services rendered and laboratory data ordered on his patients.

The initial discussion resulted in his informing us that he was a very careful physician and that he wanted to be sure that everything that was best for patient care was being given because Medicare was now paying the bill. And when he was questioned as to whether these monthly visits and requests for EKGs and chest X-rays were necessary for good quality care, he could not justify this in regard to any of these patients.

He was then advised that his pattern of practice was at great variance with other Maryland internists, that he should take a good look at his practice, and that his practice would be monitored from then on.

He returned 15 months later to appear before our Peer Review Committee as it now exists; there had not been much change in his practice. His work had been reviewed thoroughly by members of the Peer Review Committee before his appearance. Dr Klinefelter will discuss committee decisions in regard to this physician's mode of practice.

What I've done is to try to show you the attitude this physician took toward Medicare patients. He had the feeling that because they were Medicare cases they were entitled to a great deal more because the government was paying the bill.

He also felt that the patient should not be charged for the copayments. You know, in Medicare 80% is paid by the government and 20% by the patient. And he did not charge them for the \$50 deductible because, as he said, his patients objected. And, lastly, he felt that routine annual examinations were paid for by the government which, as all of you know, is not the case.

What was the result of this physician's attitude? First, it resulted in overuse of laboratory facilities. It was estimated that at least 50% of the laboratory work he did was unnecessary as were 80% of his EKGs.

We also felt that he had misused these labora-

tory facilities and ordered tests that were not indicated just because he felt they were something the patients deserved because their bills were being paid by the carrier. This resulted in overdelivery of health care, if you want to call it that, and he had these patients coming back once a month for visits which, many times, were not necessary.

He was also overcharging for health care. Many times he would get tests that could have been done in group or in bulk, such as an M-12 if indicated, and charge the patient separately for each test. And some of these tests were done in his own laboratory. And, lastly, it was learned that 60% of his income came from Medicare patients, constituting about 30% of his patient load.

What positive results were achieved by the Peer Review Committee?

Well, first of all, we found out later from the third-party carrier that this man did change his mode of practice to conform with the practice of his peers or the other internists in the community.

Secondly, because he did change his mode of practice, he was able to give better health care delivery because he was able to deliver care to people who needed it much more than to the people he was giving it to who really didn't need it.

And, thirdly, the last thing that resulted was that he did reimburse the carrier with \$30,000 of funds which he had collected over the preceding two years.

Dr Cocco: I think this case is illustrative of a problem that confronts us frequently; namely, the disparity in a bill between what the doctor thinks he is worth and the total expenditure with regard to laboratory services. I don't believe we have ever argued with a physician about what he thinks his service is worth; however, when it is disproportionate to the total bill and the remainder is taken up in laboratory studies, something is wrong with the system.

CASE #3

The next case presentation will be by Drs Leeds Katzen and John R Davis.

Dr Katzen: This case was referred to the Peer Review Committee from the carrier because of the disproportionate amount of EKGs performed compared to the total number of EKGs submitted for reimbursement to the carrier. It was also noted when reviewing these EKGs that about 75% (861) were for the Master's test rather than the ordinary EKG (211).

In the course of discussion with the physician



AUDIENCE ATTENTION at the Peer Review discussion was intent as depicted in this partial view.

it was learned that the Master's EKGs were not performed in accordance with accepted community standards. We learned this by sending the EKGs out to a group of cardiologists and asked their opinions, even though we have cardiologists on our own committee. We do this frequently if we need consultation in a special field.

We found that the EKG interpretations were being performed by another physician, a consultant, rather than this physician. This consultant was paid on a per-interpretation basis. Nevertheless the original physician was billing at a rate of \$25 per test including tracings and interpretations.

Regulations require that the technical aspects of the EKG be paid at a rate lower than both the technical and professional aspects. After we reviewed this data, we asked the physician to come before the Peer Review Committee and explain his mode of practice. Dr Davis will give us the results.

Dr Davis: The physician told us he had no special background in cardiology; that none of these tests were done for special disability claims; but, because of the patient's condition or complaint. When we asked him what criteria he used for doing a Master's, he said that if a patient had a complaint such as a chest pain and had been a heavy smoker for many years that he would perform a Master's; also as part of a thorough work-up; and in general by the patient's condition.

He admitted that he was present only occasionally, that his two nurses usually performed these tests, and that he merely interpreted the tracings. He guessed that about 25% or more of his patients had some type of heart disease and estimated that 20% or more produced positive abnormalities.

We felt that the physician was very straightforward, honest, and frank. If he was hostile, he had it well concealed because his attitude was favorable. After studying all facets of the prob-

lem, we felt that he probably had inadequate cardiology consultation and some of the interpretations left a lot to be desired.

After explaining all the facts to this doctor, we concluded that he was rendering a good service to his community and that he really wasn't too far out of line. I believe he learned a lot from our committee. And, in addition, the carrier received a refund of about \$7,000.

Further Discussion

Dr Cocco: The cases presented are not unusual. Obviously, we have had some very bizarre cases; but this is not, I think, what peer review is all about.

A Doctor: Don't you think it's fair to say that in every case it was educational?

Dr Cocco: I think that's true. But I also think that to sell peer review purely as an educational experience is probably not right. Obviously, there are punitive aspects. There are monies that are denied, refunds that are suggested; occasionally, cases are referred for more difficult disciplinary actions. I certainly think that the educational aspect of peer review is indeed very important; by the same token, I don't believe that one can sell it totally on the basis of education.

A Doctor: Are reimbursements recommended by the committee or the third party, was a legal opinion rendered, or was this voluntary?

Dr Davis: As I understand it, they are worked out between the doctor and the carrier. To my knowledge, we have never entered into it. We have made a few recommendations, but we have never tried to set the figure.

Dr Cocco: At times we have felt that a portion of the service was not appropriate and recommended that a portion of the service not be paid. However, we're not being dictated to by the carrier in any instance. There are instances in which we have felt that the claim was justified and that the insurance carrier should be made to realize that the claim was justified. Dr Kime, could you present some of the dealings that the committee has become involved with regarding perusal of the laboratory aspects of medicine?

Dr Kime: The process of peer review opens a number of avenues for self-evaluation, and it becomes apparent that there is a changing pattern in reimbursement for laboratory services as paid by Blue Shield and some of the other third-party carriers.

An increasing amount of laboratory work is being done in physicians' offices; the burden is the physician to justify the laboratory work and to prove that the laboratory work was equal to that of the licensed and accredited laboratories.

As a result, and through cooperation of the Maryland Society of Internal Medicine, a pilot project was performed in which volunteer internists with laboratories in their own offices participated in a proficiency survey. The results were part of a Master's paper via the Johns Hopkins School of Public Health and Hygiene. The results were somewhat surprising to the participating internists for, when compared with local hospital laboratories and some of the larger private laboratories, they did not do as well as they had expected.

Recognizing this, they agreed that a general form of laboratory evaluation for the physician's office would be a good thing. As you are probably aware, the Council has accepted the proposition that a physician who performs laboratory work should participate in a proficiency survey. This is a good example of something that developed out of evaluation of the sort of laboratory work being performed throughout Maryland, a recognition of the need for quality control and proficiency survey in the physician's office.

Dr Cocco: Dr Page, do you think that the Peer Review Committee in Maryland is doing what other people are doing around the country and in your own state of Oregon? And are you actively involved?

Dr Page: First, I'm not actively involved. Second, I think the peer review group in Maryland is far ahead of most state societies in actually functioning as a peer review group. From what I've heard, I think you are somewhat more effective than they are in Oregon. You certainly have a very vigorous and effective program.

Dr Cocco: Dr Klinefelter, do you want to explain further the relationship we are trying to establish between the State Peer Review Committee and the local peer review mechanism?

Dr Klinefelter: It seems that the State Peer Review Committee was the first one that was created and we were the ones who got the first "cases." As peer review groups are formed within local component units, we hope that they will take these cases and decide on them at the local level. Med-Chi Bylaws either have been or soon will be amended to make it possible for anyone who is dissatisfied with the opinion of the local peer review committee to appeal the decision to the State Peer Review Committee; so, there is a mechanism provided to anyone who is seeking to appeal.

It seems that the input to the Peer Review Committee nearly always originates from third-party carriers after the computer "flagged" obvious abuses of laboratory charges, X-rays, and EKGs such as Dr Borkovich reported. I'd also like

to ask Dr Page if it is true that physicians supply input in other parts of the country.

For instance, a patient came into our office recently who was sent by his employer for evaluation. He had been going to another physician for four years and receiving an EKG every six months and having his cholesterol level checked every two months. The poor fellow was scared to death and there wasn't anything wrong with him. Personally, I think this ought to go before the Peer Review Committee. It seems to me that physicians should at least tell the Peer Review Committee about situations they discover in their practice.

Dr Page: I agree that physicians should be willing to have input. I think it has been too minimal. The tendency is not to become involved. I think, to be effective, they're going to have to require real input from practicing physicians; but it does not work too well.

Dr Wiswell: I'm not sure that a peer review committee should involve itself with individual cases because the minute you start to discuss a specific case with a physician—I don't care whether you hate or love him—you're going to come to a disagreement about the minute specifics of that case.

I think that peer review—if it is truly to be educational and is to have a significant impact upon the general mode of medical care—must deal with patterns of practice. And this is why I think computer information is so useful to us.

While I don't disagree that there are cases of individual differences of opinion that possibly should be discussed, I think there is so much work to be done with the mass of information now being developed that we cannot bog ourselves down with worrying about a specific case. So I would say that if you know a physician who constantly does the same thing, that is one thing; but, if we are going to discuss a specific case, whether or not we agree that he did it right or wrong, I think we are going to be left with just an interminable argument and no real educational value.

Dr Cocco: I think there is probably room for both areas of review. Unfortunately, the computer mechanization is not at the stage where patterns can be recognized clearly. I think that the overt violator of a pattern of practice sticking out three standard deviations from the mean probably does not even require a computer to pinpoint. Hopefully, as computer technology evolves, it will be easier to spot extra laboratory, extra electrocardiograms, overutilization, or underutilization.

A Doctor: Have there been any complaints or cases brought to the Peer Review Committee from carriers other than Blue Shield?

Dr Borkovich: Yes, from several commercial carriers. About a year ago representative from the national level of two of our largest commercial carriers met with the Peer Review Committee. They are very interested in our activities. At the present time, one of the large companies is sending quite a bit of information to us. And I can tell you that they have some very well trained non-MD personnel doing a very good job abstracting the records.

A Doctor: I assume I know the answer already, but does a component society, upon reviewing a claim or complaint, have the prerogative of referring it back to the state level if it feels it cannot handle it adequately?

Dr Wiswell: Yes, we have reviewed quite a few cases that have been handled by the component societies who were requesting consultation and review of their final decisions. I think it all boils down to a stimulus for all of us—and none of us knows everything—to keep learning. In one instance, a physician was interviewed and we recommended that he take, for the next year or perhaps for the rest of his life, some continuing programs in education. We recommended specific courses offered by both Maryland medical schools. He had not been to a postgraduate course for several years; we thought that if he did so he might be able to improve his mode of practice, which, in our opinion, was not very good.

Dr Cocco: The education aspect cannot be emphasized enough. Frequently, in any national health system or third-party system of review, the economic aspect may be glaring and the pattern of practice unusual; but, upon actual review of the doctor, it is obvious the quality of practice is in serious trouble. This is why it is inconceivable to me that PRO can be done with any degree of efficiency by anyone other than physicians.

There are some instances—fortunately very few—that have disclosed some overt fraud. The mechanism in the Medical Practice Act of Maryland is unique since problems can be defined in an investigating committee such as peer review and the case formulated and taken before the Commission on Medical Discipline which can have very serious results.

Dr Katzen: I think we should make it clear that in most cases—at least on patients who have been hospitalized—we not only have the information from the carrier but that we do get copies of the hospital record and that we do review

them. Some hospital and office records are rather poor; we are looking forward to improvements; many hospitals are instituting the WEED system, which ought to make records much easier to review.

Dr Cocco: You are touching on an area that I wish you would go into further, and that is the question of whether on-site office review or audit should be considered as an integral part of peer review.

Dr Kime: What we have done is to restrict our evaluation to a pattern of practice in the first place in committee.

Where it becomes obvious in talking to the doctor that either the mode of practice is quite bizarre or that his own knowledge of the treatment and handling of patients with diagnoses that he made is deficient—and we have had this—then one of the members of the committee arranges to visit with the doctor in his own office.

In each of these cases we have been able to obtain good insight into the manner in which he practices. We have never walked in and said we will; we have always told him we would like the opportunity to discuss this with you in your office. And I think all of us who have been to the offices have come away feeling that in the main the office record does not substantiate the work that the doctor has said he has done.

I think so many of us look upon our records as just a working document, just something that will remind us who Mrs Brown is and what did we last do for her, while we carry the bulk of this information somewhere in the back of our heads. But I think the time that we could use the office record for this narrow facility is gone. I think we have to say, as we have always said in peer review, that I feel I ought to be able to justify to my fellow physicians everything that I've done.

I suppose pathologists are peculiarly susceptible to this process because those of you who are not pathologists always seem to want another pathologist to look at the slide. So we have been in the habit through the years of looking at a slide, making a diagnosis, and then quickly in the back of our mind saying, well, I wonder if Russell Fisher or Paul Guerin or somebody else would call it the same way.

Now this is a thought of ongoing peer review. And I have to feel that if we as physicians say, all right, I've done the case, I've finished it; now, if this case has to be transferred out of state to a good friend of mine who went through medical school with me in California, what would he think of my record; would he really be impressed with it or would he say, gee whiz, that

guy's really slipped since I knew him in medical school?

So I think part of peer review's problem is a mental attitude that we approach it with. We tend in the main when we first hear about it to consider this demagogic intrusion of the third party, the federal government. But peer review really isn't that. I frankly don't give a damn what Blue Shield thinks or what Blue Cross thinks, as long as my peer group agrees that I have done my job appropriately. Because when my peer group agrees that I have done my job appropriately, we stand together to explain to the third party that they don't know what they're talking about. Unless we have the support of our peers, we cannot explain to a third party and those who would control us why we did what we did and why we did what we did to be correct.

Dr Cocco: We have had other interesting experiences in reviewing physicians, especially as to inpatient utilization where we have found that a physician is working as efficiently as he can in that set of environmental circumstances. Obviously, in that situation, the hospital needs some change, and we recommended certain changes to the Joint Commission on Accreditation of Hospitals as well as hospital utilization review.

Dr Page: Perhaps you know that in New York and some other states that, by law, any medical care receiving state funds, the Public Health Service has access to those records. I think this could very easily be done by the federal government. I know we don't like to have doctors snooping around our offices, but I think we are better off having doctors doing this than we are in having somebody from the Public Health Service or a federal bureau do the snooping.

A Doctor: Dr Cocco, what do you do with the material after the review is complete?

Dr Cocco: The actual material is returned to wherever it came from, and if there are copies they are destroyed. Once the case has been reviewed, the proceedings of the review are kept in the minutes of the committee.

In conclusion, I think that you can see that we are concerned and that we are aware that everything is not right in medicine. We are also aware that society is changing and that the aspect of health care is a right. It is also a commodity, and this commodity ought to have a value placed on it. This value should be subject to scrutiny, and we have the responsibility and obligation to explain to those paying the bill where the money is going and what it is going for. As physicians, we must continue to concern ourselves with the quality of all health care delivery.

GAS GANGRENE OF THE EXTREMITIES

T H MORGAN MD

Professor and Head

Division of Orthopaedic Surgery

University of Maryland

Baltimore

and

S H CHIU MD

Resident in Orthopaedic Surgery

University of Maryland

Baltimore

Information and reprint requests to Dr Morgan at 550 N Redwood St, Baltimore, Md 21201.

Introduction

Gas gangrene is still one of the most feared complications in the management and treatment of extremity injuries. Fortunately, due to a better understanding of the principles of debridement of devitalized tissue and the advent of antibiotics, there has been a very substantial decline in this particular complication during the past 60 years. Nevertheless, it continues to occur throughout every country in the world and remains a hazard that requires the most intensive and rigorous treatment when diagnosed. There is little doubt in the minds of most authors that many cases could have been avoided by adequate initial management of the injury.

Review of the Literature

There are still some authors who cast doubt on the efficacy of hyperbaric oxygen treatment as an adjunct to the standard therapy for the management of the infection, although most authors concede that, while hyperbaric oxygen itself is no substitution for other methods of treatment, it is a most valuable adjunct therapy.

Much of the credit for our knowledge on the use of hyperbaric oxygen must be given to Dr Boerema of Amsterdam and his coworkers. Attempts, however, to determine from the literature a correlation of the mortality and morbidity between series treated by standard therapy with hyperbaric oxygen and similar series without hyperbaric oxygen tend to be frustrated by the fact that no truly equivalent series has been reported. There are numerous references in the literature concerning series of patients with clostridial infections treated both with and without hyperbaric oxygen, but many of these series contain lesions other than that arising in the extremities, including postpuerperal infections, abdominal wall infections, etc. Furthermore, there appears to be a wide variety of presumed severity of the infection judged by the analysis

of the length of the time the infection had been established prior to therapy.

In 1966 Isenburg, reviewing 25 infections, reported a 66% mortality of patients treated by regular therapy without hyperbaric oxygen. This series did, however, include a number of abdominal infections.

In 1967 Jones reported 40 cases of clostridial infections treated in the hyperbaric chamber indicating a mortality of 20%, but stated that only one death was the direct result of the gas infection.

Hitchcock, in 1967, reviewing a series of 32 patients, of whom 26 were treated by hyperbaric oxygen, concluded that "in a group of 18 patients determined to have severe diffuse spreading myositis with systemic toxicity, there was an 83% rate of control of the infection," and he concluded with the fact that, in his opinion, the hyperbaric chamber for this type of infection was truly lifesaving.

Cole, Will, and Modely, in 1967, quoting van Zyl, reported a summary of the literature in which 170 patients with the infection were studied. It was noted that, by using all forms of treatment, death from gas infection occurred in 23% of patients from all causes including complications and unrelated causes.

In 1971 Altemeier reported 54 cases of gas gangrene treated without hyperbaric oxygen in which the mortality was 14.8%; in his opinion hyperbaric oxygen would appear to be of relatively little value, particularly in relation to the correct surgical and therapeutic management.

It is therefore quite apparent that it is extremely difficult, if not impossible, to determine the precise mortality of gas infections restricted to extremity injuries treated with and without hyperbaric oxygen.

Material and Statistics

This paper concerns 20 consecutive admissions of patients with gas gangrene to the Shock Trauma Center at the University of Maryland Hospital, where the full facilities for hyperbaric oxygen therapy exist. The patients ranged in age from seven to 60: two were female and the remaining 18, male. Nineteen of the 20 patients had been transferred to the Unit from other hospitals, specifically for the treatment of gas in-

fection. In the remaining patient, the infection arose while under treatment in this hospital for severe compound injuries to the upper extremity where vascular repair had been undertaken in attempts to save a limb.

The majority of our patients were seen relatively late in the disease and many had multiple hospital transfers prior to the admission to the Unit. With two exceptions, all were extremely toxic on admission; the average time that had elapsed since injury was 3.5 days (varying from one to seven days). All the patients transferred had surgery of some type prior to admission; in approximately 50%, the surgery had been definitive, often ablative, in an earlier attempt to control the disease. In many instances, despite radical treatment prior to admission, both by surgery and antibiotics, the disease had progressed. The etiology of the infection is as follows:

Table A

Auto Accident	10
Gunshot Wounds	2
Industrial and Farming Accident	3
Drug Abuse	2
Diabetes	2
Elective Surgery for Home Trauma	1

From this table, it can be seen clearly that the majority of cases resulted from severe trauma; in some of these there was clear evidence of inadequate primary treatment. Avascularity, due in some cases to known arterial damage, was a frequent, almost constant, finding. The majority of patients had a variety of antibiotics prior to admission.

In 14 of the patients, the lower extremity was involved; in the remaining six the upper extremity, including one case in which there was severe infection, involved the lateral chest wall. In many instances where the lower extremity was involved, there was clinical evidence of spread of gas, as determined by crepitation and radiological changes well above the hip joint into the flank, and, in a few patients, high up on the thorax.

As stated by other authors, the diagnosis is essentially on clinical assessment. The combination of necrotic or ischemic tissue, pain, hyperpyrexia, toxicity, crepitus, and radiological evidence of gas in the muscle, coupled with the identification of gram positive rods from the wound, is considered sufficient diagnosis to justify immediate hyperbaric oxygen treatment.

Smell from the wound is always a less reliable feature; it has been pointed out that certain strains of clostridium produce very little in the way of smell, the smell coming mainly from secondary organisms.

In the majority of the patients, the disease was confirmed by bacterial culture from the wounds; in one patient, a positive blood culture was obtained.

Method of Treatment

Following admission to the Shock Trauma Unit, patients were immediately monitored with correction of electrolyte imbalance; blood transfusion appeared invariably necessary. Massive therapy was given with antibiotics; initially penicillin was considered the drug of choice; more recently we have changed to methicillin, as this is believed to be more effective in anaerobic conditions. Careful assessments by clinical, bacteriological, and radiological techniques were performed and the hyperbaric oxygen therapy commenced in 19 of the 20 patients. Eighteen of these were treated by the regime recommended by Dr Boerema; surgery, when necessary, was performed between the second and third dive. Each dive lasted approximately two hours at three atmospheres; the number of dives necessary varied from four to 11, being determined by the clinical response of the patient.

Further surgery was considered necessary in 18 of 20 patients; amputation or reamputation in those who had already had ablative procedures was performed in 14 of 18 patients. In ten of these, ischemia, either total or partial, was the factor which predetermined this method of treatment. In one patient, severe orthopaedic problems of the extremity, which in themselves may have justified amputation, were additional causative factors. In four patients, local surgery was possible and the extremity was saved. In two patients, no further surgery was considered necessary. Where amputation was performed, in most instances it was considerable distal to that which would have been necessary had the infection not been controlled by the hyperbaric oxygen therapy and the antibiotics.

Where amputation or reamputation was necessary, the level of amputation was largely dictated by the level of ischemia and the level of skin viability. The guillotine type of amputation was never performed, skin flaps being invariably left allowing easy secondary closure of wounds, usually some four to five days after admission to the Unit.

The average length of stay of these patients in the Shock Trauma Unit was 4.2 days, excluding one patient who remained for other complicating problems for a period of 53 days.

Results

Of the 20 patients reported in this series, two died. One patient with very severe infection on

admission died on the sixth day from intracranial hemorrhage, which was possibly related to the gas infection due to a disorder of blood coagulation. At autopsy, there appeared no evidence of any local infection in the amputation stump or other evidence of a generalized clostridial process.

The second death was a man who had long since recovered from his gas infection, but who eventually died of pseudomonas pneumonia. This patient, at the time of admission, was known to have had a severe respiratory problem secondary to inhalation of vomit at the time of the accident.

The other 18 patients survived; in no case was further treatment necessary for the clostridial infection, although it is pertinent to observe that in some patients healing wounds cultured the clostridium organism for a period of up to six weeks following initial infection.

From this, one can conclude that in every case the combination of adequate resuscitation, blood transfusion, antibiotics, hyperbaric oxygen, and surgery cured the patients of their clostridial infection.

As stated earlier, it is difficult to get reliable statistics of comparable series concerning the mortality of the patients treated with and without hyperbaric oxygen. Nevertheless, in the opinion of the authors, the results from our Unit suggest that hyperbaric oxygen played a profound part in the treatment and eradication of the clinical gas infection. Equally, the authors believe that judicious surgery is still a fundamental treatment, although in many patients in this series the surgery was made less extensive by the hyperbaric oxygen therapy.

Summary

Twenty consecutive patients with extremity lesions complicated by gas gangrene infection were treated at the Shock Trauma Unit at the University of Maryland Hospital through the years 1967 to 1970. Nineteen of these patients were treated, in addition to standard therapy, by hyperbaric oxygen. In every case the disease was controlled by this combination of therapy. The mortality of this series was 10% (two patients) the cause of death being not directly due to the infection, but in one instance may have been related to it.

In the opinion of the authors, hyperbaric oxygen has established its place as essential therapy for the disease in relation to the mortality; also, possibly more impressively, the morbidity in that some extremities were undoubtedly saved which would have been lost without the hyperbaric oxygen.

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**Albert M Antlitz MD, Chairman
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175th ANNUAL MEETING
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Scientific exhibits are an Integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians and medical institutions who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held at the Baltimore Civic Center on

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APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
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1. Title of exhibit:
2. Please attach a 50-100 word description of the exhibit:
3. Give amount of space required, depth, width, and height:
 If exhibit has side panels, are depth and width included above?
 If not, what additional space is required?
4. Electrical or other requirements:
5. Has exhibit been shown at other medical meetings?
6. Name and title of exhibitor:
7. Name of Institution cooperating in the exhibit:
8. Address of exhibitor:

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 500 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS,

DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.

5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
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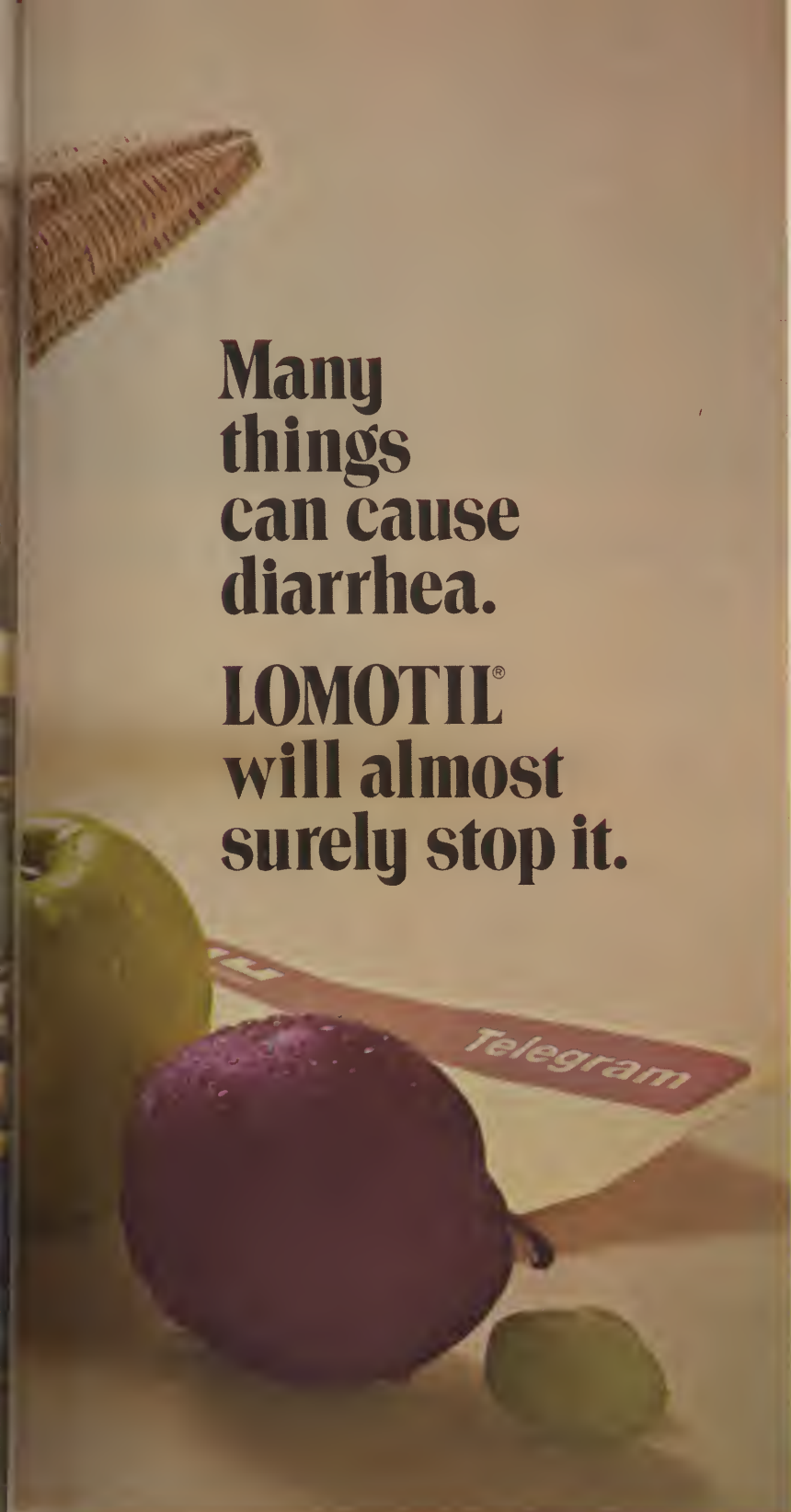
Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

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Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

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Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur

12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: *Tablets*, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid*, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

Dosage forms: *Tablets*, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid*, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.



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Patient: 47-year-old male.

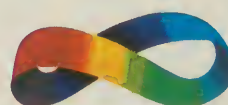
Diagnosis: Severe pyoderma, left hand.

Culture: *Staphylococcus aureus*, coagulase positive and sensitive to MINOCIN.

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Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat*, 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.

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use has not been established in children under 13.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reactions: (Common to all tetracyclines, including MINOCIN) GI: (with both oral and parenteral use): anorexia, nausea, light-headedness, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. **Skin:** maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). **Renal toxicity:** rise in BUN, dose-related (see "Warnings"). **Hypersensitivity reactions:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. **Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that MINOCIN is not notably influenced by foods and dairy products.

*Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.

†Case Report, Clinical Investigation Department, Lederle Laboratories.



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436-2

A STATEWIDE COMMUNICATION SYSTEM TO SUPPORT A REGIONAL PROGRAM FOR EMERGENCY HEALTH CARE DELIVERY IN MARYLAND

R ADAMS COWLEY MD
A BRINTON COOPER III
DAVID E TOWSON
LEONARD SCHERLIS MD
University of Maryland
Hospital
Center for Study of Trauma
Baltimore

Supported in part by the National Institutes of Health, Division of General Medical Sciences, under Grant No GM-15700 and Grant No PT 69-001 DOT.

Information and reprint requests to Dr Cowley at 22 S Greene St, Baltimore, Md 21201.

Introduction

At the University of Maryland Center for the Study of Trauma, there has been developed a successful statewide air med-evac helicopter system for transportation of critically ill and injured patients to the Center by either direct pickup at the scene of an accident or interhospital transfer. This rapid transportation system is a cooperative effort between two state agencies, the Maryland State Police and the University of Maryland, and would not have been possible without the resources of the already well-developed State Police communication network.

Basically this communication net is connected by a radio-telephone patch system throughout the state between state police patrol cars and regional police barracks feeding into a central receiving and dispatching center located at the Valley Post barrack and thence by direct line to

the Center. After three years experience in transporting over 1000 patients,* it has become apparent that other State resources must be pulled together if better health care delivery is to be provided and duplication of systems prevented. Therefore, it is logical to develop a common communication network to connect regions throughout the State so that all medical resources can be used.

The purpose of the communications system is to make possible a significant improvement in the quality and speed of delivery of emergency medical services by providing a means for achieving closer cooperation between existing and future medical resources. These resources include ambulance and rescue vehicles, Maryland State Police helicopters, hospital emergency rooms, intensive and coronary care units, hospital specialty referral facilities, and the fire department central alarm headquarters. A major objective in planning this system has been the provision of new capabilities for emergency health care without inconveniencing or limiting the operation of the present ambulance control system.

At present there are two

** Two hundred of these patients were infants born with life-threatening problems transported to regional intensive care nurseries at the Baltimore City Hospitals and the University of Maryland Hospital. This innovative program was developed by Dr Herman Reisenberg and Dr Ronald Gutberlet.*

means of transportation available for patients who because of their life-threatening problem require rapid transportation in special vehicles. The first is the city and county fire department ambulance services which are the envy of most regions throughout the country. These services consist of programs sponsored and controlled by fire departments, both private and volunteer, except in western Maryland where private ambulance companies also assist in emergency health care delivery. The fire department central alarm headquarters is responsible for dispatching fire-fighting equipment and ambulances. Ambulance requests are made by police, physicians, hospitals, or citizens calling the central alarm headquarters in that region. At the accident scene the ambulance crew provides first aid to the best of their ability and then transports the patient to the nearest hospital.

The second means of transportation is the Maryland Air Med-Evac Helicopter System, which has also become a national model, devised to secure appropriate, timely medical care at specialized facilities for the critically ill and injured who would otherwise die. The special advantage of the helicopter is its ability to provide rapid transport over long distances or from areas inaccessible to the ambulance. However, both transportation systems provide outstanding service and each complements the other.

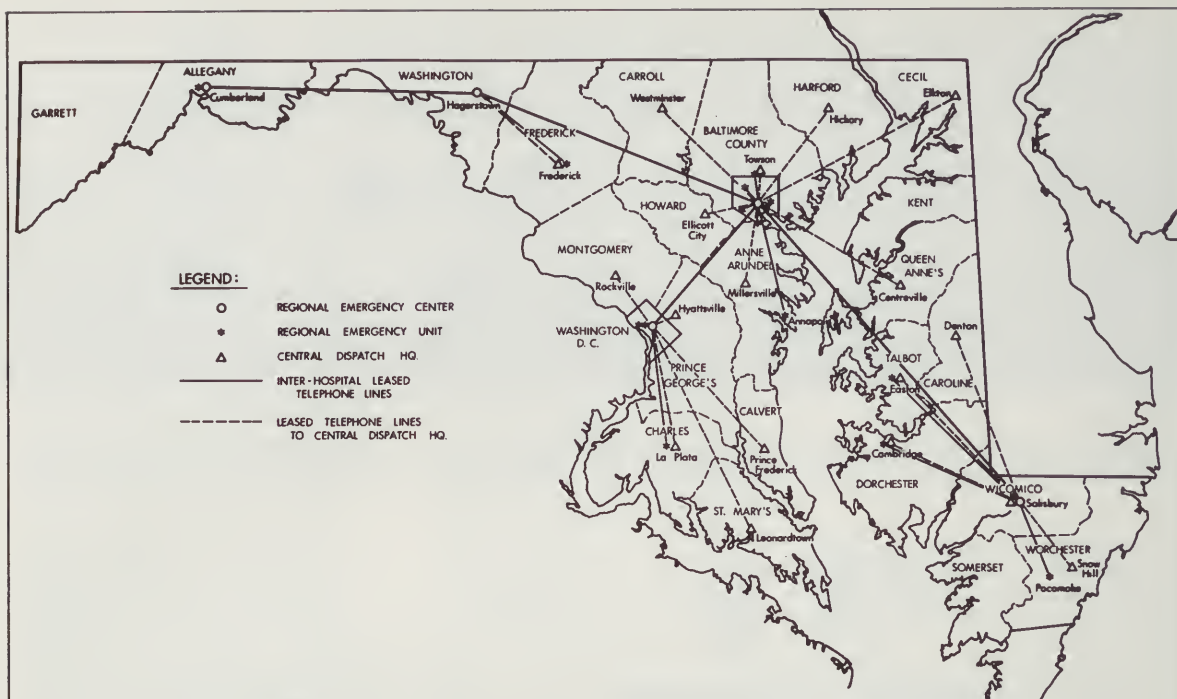


Fig 1:

This map shows how a statewide communication system could be implemented by incorporating five regions:

- 1) Cumberland—Appalachia region
- 2) Hagerstown—Frederick region
- 3) Baltimore Metropolitan region
- 4) Washington, DC—Montgomery—Prince George's County region
- 5) Salisbury—Eastern Shore region

A hospital in each area would be selected as Regional Emergency Center on its ability to give multidisciplinary 24-hour-per-day care.

They would be supported by Regional Emergency Units and participating hospitals. Selection of hospitals on this map are only pointed out to give substance (see text). Each of the five centers is connected by private leased lines to the Central Communication Center in Baltimore. Each regional center is connected to its Regional Emergency Unit hospitals and Central Dispatch Headquarters by leased telephone lines. Each regional center communicates with each other and with the ambulance crew at the scene of the accident by radio.

In a statewide communication concept proposed here, Maryland is divided into five regions. A hospital would be chosen in each as a Regional Emergency Center based on its ability to give multidisciplinary care on a 24-hour basis. This hospital would be supported by strategically located hospitals in the region called Regional Emergency Units. Other hospitals supporting the regional concept, to be known as participating

hospitals, would provide the remaining necessary medical resources. These hospital categories would be chosen by physicians at the community level in accordance with their ability to provide the appropriate emergency services.*

** Means for evaluation of hospitals at the regional level have already been developed by the excellent effort of the Baltimore Metropolitan Regional Planning Council's Committee on Emergency Medical Services.*

Specialty Referral Facilities now participating in the system include the University of Maryland Center for the Study of Trauma, the Baltimore City Hospitals Burn Unit, and the Johns Hopkins Pediatric Trauma Center. Other Specialty Referral Facilities will be added as they develop. The backbone for such a regional concept is a statewide communication network linking these facilities (Fig 1). Statewide coordina-

tion of the system will be accomplished by the CST serving both as a regional center and a statewide communication control center.

Operation of the Emergency Medical System

The proposed emergency medical system operates in the following manner. When an emergency arises, help is summoned in one of several ways: Police may radio from the scene of the accident, a friend or relative may call a telephone operator for assistance, or a passerby may telephone the local county or city fire department central alarm headquarters (Fig 2). Any of these calls results in the dispatch of an ambulance. If the central alarm dispatcher has reason to believe that a life-threatening situation exists, he may request helicopter support at the same time. Upon arrival, the ambulance or helicopter crew provides first aid and examines the victims for symptoms of life-threatening injuries. If none appear, the patient is taken by ambulance to the nearest hospital emergency room. Ninety percent of all ambulance runs will continue to be managed in this way.

If it appears that a life-threatening situation exists, the ambulance attendant requests and obtains transportation instructions and/or medical advice by radio from a Regional Emergency Coordinator located at the nearest Regional Emergency Center. If necessary, the coordinator may also place a physician in contact with the ambulance. If the med-evac helicopter crew arrives at the scene first, they will transport the patient to the appropriate Specialty Referral Facility and notify

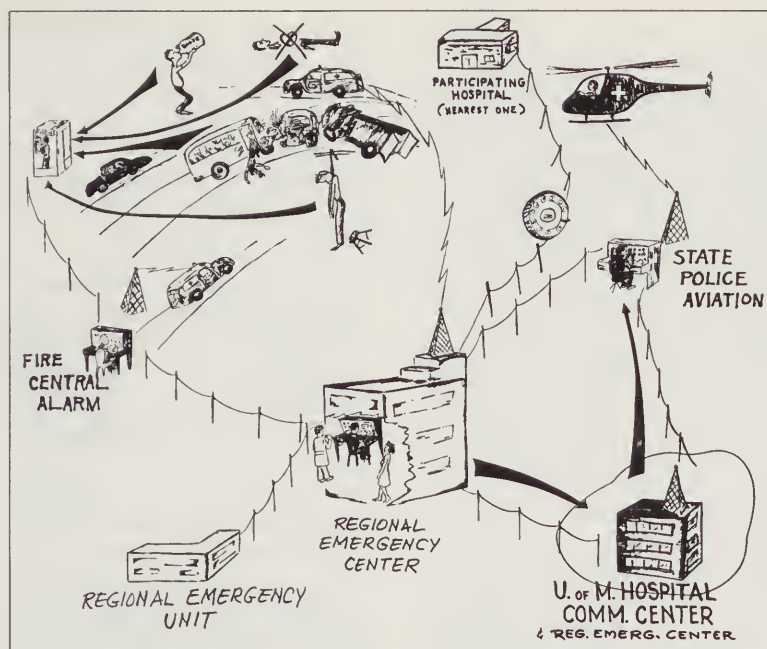


Fig 2:

This drawing considers those life-threatening problems that would be managed by the communication network. Left upper corner shows the accident victim, the heart attack patient, the severe alcoholic, drug addict, psychiatric patient, or neo-natal problem (not shown) entering the system when the observer dials "0" or "911." Following the drawing counter-clockwise a central alarm headquarters is shown dispatching the ambulance and calling the Air Med-Evac helicopter, the Regional Emergency Center providing instructions to the ambulance crew at the scene, and reporting data to the University of Maryland Central Communications Center Trauma Registry. This patient would be directed by the Regional Emergency Center to the nearest indicated Regional Emergency Unit, the nearest participating hospital, or to one of the Specialty Referral Facilities in Baltimore. Note that the participating hospital enters the system by dial telephone.

the central alarm headquarters that the pickup has been made. If the patient is not critically injured, resuscitation and first aid are provided until the ambulance arrives and the patient is removed to the nearest participating hospital.

On receiving a call from an ambulance, several courses of action are open to the coordinator:

- 1) If conditions warrant and resources are available, he may advise transporting the patient to the nearest hospital emergency room.

- 2) He may advise transporting the patient to another hospital having certain spe-

cialized facilities.

- 3) He may request the dispatch of a Maryland State Police helicopter to evacuate the patient to the appropriate Specialty Referral Facility. In this instance, the ambulance or rescue crew will remain at the scene to give first aid and assist in loading the patient into the helicopter.

- 4) If there is a suspected cardiac emergency, on-the-scene treatment can be given in accordance with instructions received by radio from a cardiac specialist.

The success of the system in improving the quality of emergency health services depends on the ability of am-

bulance crews to recognize life-threatening injuries and to request direction from the regional emergency coordinator. This coordinator must know the nature and the availability of the resources servicing the region. These are census of available beds, a list of emergency rooms able to accept the patient at that time, the location and status of the med-evac helicopter serving the region, and the identity and location of specialists on duty. If any of the above resources essential for the care of the patient are not available, the regional coordinator will then request assistance from the Communication Control Center located at the Center for the Study of Trauma.

Following the categorization of hospitals, the management of non-life-threatening injuries may be improved by enabling the ambulance driver to confer by radio directly with the Emergency Room of any nearby large community hospital having around-the-clock capabilities.

Communication System Description

The communication system combines existing facilities for dispatching ambulances, rescue vehicles, and helicopters with new facilities for inter-hospital communications, two-way voice communications between ambulances and regional centers, and EKG telemetry from ambulances to regional centers.

Interhospital communications are provided by leased telephone lines connecting each Regional Emergency Center with the Communication Control Center. Leased lines also connect each Regional Emergency Center to Regional Emergency Units

and central alarm headquarters. Other hospitals participating in the system enter by means of conventional dial telephone service. A back-up capability for these telephone lines is provided by the radio system described below.

Two-way voice communication between ambulances and Regional Emergency Centers is provided by transceivers (transmitter-receiver sets) installed in each ambulance, rescue vehicle, and Regional Emergency Center. These radios operate on frequencies allocated by the Federal Communications Commission (FCC) for Special Emergency Radio Service. This equipment supplements the existing ambulance radios presently used for dispatching. In addition, each ambulance is equipped with a light, portable "walkie-talkie" transceiver enabling two-way communication from the patient's side when he is located some distance from the ambulance.

When the need arises for a physician located in a remote region to communicate with the ambulance, a manually operated telephone-to-radio connection can be made at a Regional Emergency Center enabling two-way voice communication between an ambulance and any other point in the State.

A back-up channel for communication between ambulances and physicians is provided by the leased telephone lines between each Regional Emergency Center and the central alarm headquarters. If the ambulance is unable to contact the Regional Emergency Center via the "special emergency" radio, contact can be established through the central alarm headquarters by requesting the ambulance dis-

patcher to make a telephone-to-radio connection. The ambulance attendants can then talk to the Regional Emergency Center via the dispatching radio.

Communications with other large community hospitals (for major non-life-threatening situations) is provided by adding a channel to the "special emergency" ambulance radio and by installing transceivers at these hospitals. These hospitals have to be licensed separately through channels by the FCC for such operation.

Electrocardiography telemetry permits one-way transmission from the ambulance to the Regional Emergency Center making use of the recently authorized frequency allocations for telemetry in the 460MHz band (Fig 3). Although initially intended only for EKGs, this capability can be expanded later to include telemetry of other biomedical parameters. There are two alternate methods of transmission. If the patient is in the ambulance, the biomedical sensors are connected directly to the vehicle-mounted telemetry transmitter. If, however, it is preferred not to move the patient to the ambulance until initial treatment has been administered, a low-power, hand-portable transmitter can be used at the patient's side. The signal from this transmitter is received in the nearby ambulance and retransmitted at a higher power and different frequency by the vehicle-mounted radio, which now functions as a "repeater" station. When this method of transmission is employed, the previously described hand-portable, two-way radio is carried to the patient and is used for voice coordination of the telemetry transmission and for

EKG TELEMETRY

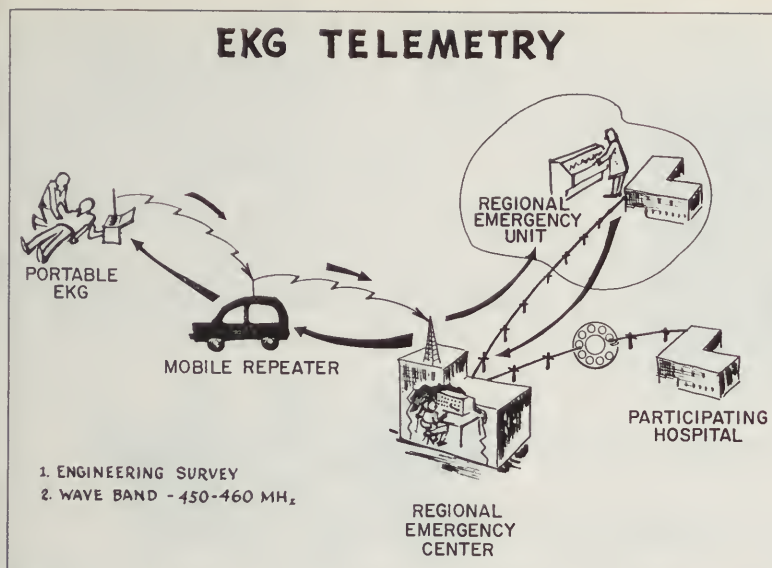


Fig 3:

This drawing is self-explanatory. Portable EKG equipment is carried from ambulance to the patient, EKG telemetry is retransmitted by the ambulance to the Regional Emergency Center. This signal is relayed to that coronary care unit where there is a cardiologist on call at that time of the day. He guides the ambulance technician in performing on-scene therapy and manages the treatment of the patient en route to the nearest appropriate coronary care unit. With this system, a patient in Appalachia with a heart attack could be directed and guided to the nearest coronary care unit by a cardiologist located in Salisbury.

supervision of the patient's emergency treatment. If this low-power radio cannot be heard at the Regional Emergency Center, the transmission can be received instead in the nearby ambulance and a member of the crew can relay messages via the vehicle radio. In either case, voice communication can take place while the telemetry is in progress.

In addition to the equipment described here, recording, monitoring, and display equipment are required at the Regional Emergency Centers. A multiple-channel audio tape recorder provides a permanent record of all voice communication passing through the center. Another audio tape recorder stores EKG signals for retransmission and record-keeping. Display panels are provided indicating regional information such as bed availability, emergency

room status, staff availability, helicopter status, and communications systems status.

System Implementation

The first requirement for implementation of the system is assurance of the participation of existing communication and transportation resources. Thus, the interest and cooperation of each emergency ambulance service in the state is required. It is important to demonstrate to the operators of these systems that the planned additions will enable them to become a vital part of an improved health care delivery system, that will neither usurp nor hinder their normal dispatching operations. Also, in areas where the only emergency service is provided by the private ambulance companies and/or funeral directors, careful coordination must be effected to insure the proposed changes

will not adversely affect their effort.

Second, to insure an effective and economical system design, competent engineering consultants must be engaged who are neither hardware manufacturers nor manufacturer's representatives. It will be the job of these consultants to survey each region for radio sites providing adequate coverage of the region for the two-way voice and one-way EKG telemetry systems. They will then prepare a system design defining items such as station locations, antenna heights, antenna types, and transmitter power. License applications will be prepared to obtain authority for operation of the system with the consultant held responsible for seeing that all FCC requirements pertaining to the licensing are met. The consultants will also prepare detailed technical specifications for the procurement of radio equipment, terminal equipment, status boards, EKG equipment, and telephone service. They will then assist in evaluating contractors and their bids and, finally, will supervise the installation and test of all equipment.

Third, additional orientation and training of ambulance personnel will be necessary. In particular, crews will need training in recognizing and treating life-threatening injuries as well as orientation providing a good understanding of system operation and the new services made available to them. Personnel for ambulances specially equipped for cardiac emergencies will require extensive training in cardiac resuscitation. The training of these crews should be undertaken well in advance of the equipment installation.

Fourth, the Trauma Registry as developed by Boyd will continue to be an integral part of the program and will become of significant importance in evaluating system effectiveness.

In conclusion, the statewide communication system for emergency health care delivery should be undertaken now

to assure that all future regional systems will be compatible. Within this framework each regional system can develop at its own pace.

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ART AND HOBBY EXHIBIT

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

APRIL 25, 26, 27, 1973

BALTIMORE CIVIC CENTER

APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Art and Hobby Exhibit
Medical and Chirurgical Faculty
1211 Cathedral St, Baltimore, Md 21201

1. Title of exhibit:
2. Amount of space required—depth, width, and height
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4. Name of exhibitor:
Please print
5. Address of exhibitor:
6. Telephone number of exhibitor:

An Art and Hobby Exhibit will be held during the 175th Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to THE BALTIMORE CIVIC CENTER, Baltimore, between 9:00 AM and 4:00 PM on Tuesday, April 24. They must be removed on Friday, April 27 between 2:00 and 5:00 PM. The Faculty cannot carry insurance on exhibits, but utmost care will be taken of them. There will be a watchman on duty when the meeting is not in session. Exhibitors' personal policies will probably cover the exhibit. All entries should be submitted as early as possible.

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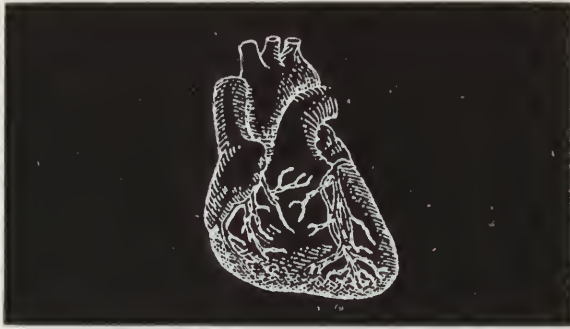
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DANIEL V. LINDENSTRUTH, MD, Editor

A Service of the Heart Association of Maryland

the heart page

Current Aspects of Digitalis Therapy

JOEL S KARLINER MD
Department of Medicine
University of California
San Diego

Information and reprint requests to Dr Karliner at 225 W Dickinson St, San Diego, Calif 92103.

In recent years substantial information regarding the mechanisms of action of the digitalis glycosides has accumulated. It is now generally accepted that the beneficial effects of digitalis in patients with congestive cardiac failure result from direct stimulation of the contractile state of the myocardium. Thus, in hemodynamic studies on patients exhibiting chronic heart failure of the low output type, it has been shown that digitalis augments the cardiac output and lowers the abnormally elevated left ventricular end-diastolic pressure. It has also been demonstrated that even though cardiac glycosides exert little effect on the pumping action of the normal ventricle as expressed in the cardiac output, they do exert a stimulating influence on normal cardiac muscle.

Myocardial Oxygen Balance

Among the major determinants of cardiac performance is the balance between oxygen supply and demand. Myocardial oxygen consumption (MVO_2) depends upon a number of factors, the most important of which are heart rate, wall tension (which is directly related to intraventricular pressure and heart size), and the contractile state of the myocardium. It appears that the increase in contractility produced by digitalis augments MVO_2 . However, reduction in heart rate caused by digitalis tends to have the opposite effect. In the dilated, failing heart, which becomes smaller after glycoside administration, the concurrent reduction in wall tension counteracts the oxygen cost of augmented contractility. Thus the effects of digitalis on MVO_2 depend on the state of com-

pensation existing at the time the drug is administered.

Vascular Effects

The effects of digitalis on flow and resistance in various vascular beds have only recently been determined in the conscious dog. After full recovery from the implantation of Doppler flow probes on the aorta and left circumflex coronary, it was found that ouabain caused coronary vasoconstriction despite the increase in MVO_2 which would have been expected to produce dilatation in the coronary vascular bed. Whether the results in normal dogs are applicable to patients with coronary vascular disease remains to be demonstrated. In normal conscious dogs with chronically implanted flowmeters, digitalis causes constriction in the renal and iliac beds, but dilatation in the mesenteric bed. In contrast, in dogs with heart failure, flow increased in all beds studied and vasodilatation occurred in response to ouabain, presumably as a consequence of increasing cardiac output, thereby reducing the reflex vasoconstriction which characterizes the low output state.

Myocardial Infarction

Although digitalis is unequivocally indicated for left ventricular failure complicating chronic valvular and coronary artery disease, the available experimental and clinical data still leave many unanswered questions concerning the role of digitalis therapy after acute myocardial infarction. It is postulated that the fate of the peri-infarction zone, with the limited oxygen available to it, is influenced profoundly by the oxygen requirements of the tissue. Increasing the

latter in the nonfailing heart of dogs with experimental myocardial infarction by means of ouabain and other positive inotropic stimuli intensifies ischemia, and ultimately results in more extensive infarction. In contrast, reducing myocardial oxygen demands by administering digitalis to the infarcted heart which is failing, may permit survival of the underperfused zone bordering the infarct.

Thus it seems clear that little is to be gained by glycoside administration to patients with uncomplicated infarction who do not have cardiomegaly. The role of digitalis therapy in the treatment of cardiogenic shock remains undefined; but, based on the data available, its efficacy in this syndrome must be questioned. Digitalis appears to be indicated for the treatment of rapid atrial fibrillation complicating acute myocardial infarction. Other supraventricular arrhythmias, such as atrial flutter and ectopic atrial tachycardia, frequently require larger doses of the glycoside and other means of therapy, such as antiarrhythmic agents or electrical conversion, may be preferable in such instances. Digitalis is commonly utilized early in the treatment of congestive heart failure and cardiomegaly complicating acute myocardial infarction, despite the paucity of experimental and clinical evidence in support of such therapy. Whether the digitalis glycosides should continue to be used routinely in such patients remains a subject for continuing clinical investigation.

Pharmacology and Assay

The metabolic half-times and excretion rates of short, intermediate, and long-acting glycosides have been well characterized. Renal insufficiency as well as old age are associated with impaired renal excretion of digitalis glycosides, suggesting that digitalis dosage should be modified in such patients.

More recently, radioimmunoassay for serum digoxin concentration has come into routine clinical use in a number of centers. Serum digoxin concentrations exceeding two nanograms (ng) / ml appear to be associated with an increased frequency of toxic manifestations. Smith and Haber reported that patients with supraventricular tachycardia and block apparently induced by digitalis, and those with ventricular dysrhythmias, had mean serum digoxin concentrations of 4.1 and 3.7 ng/ml, respectively. In contrast, patients with atrial fibrillation who had a reduced ventricular response and ventricular premature beats, and patients with sinus rhythm and second- or third-degree atrioventricular block, had levels of 2.2 and 3.2 ng/ml, respectively. Overlap may

occur and patients with levels considerably greater than 2.0 ng/ml may have no symptoms, while those with lower levels (but usually not less than 1.6 ng/ml) may demonstrate electrocardiographic abnormalities, especially ventricular premature beats. Nevertheless, in patients whose serum digoxin levels exceed 2 ng/ml, it is prudent to discontinue the glycoside until the serum level falls below this concentration. With the availability of this radioimmunoassay technique, it should be possible to analyze critically digitalis dosage schedules in relation to evidence of both beneficial effects as well as toxicity in patients with acute myocardial infarction and to determine definitively whether acute myocardial infarction sensitizes patients to digitalis-induced arrhythmias.

Although our knowledge of the mechanisms of action and clinical utilization of this most useful of cardiac drugs has advanced considerably in the past decade, much work remains. Directions for future basic research include clarification of the digitalis receptor and definition of the subcellular mechanism of glycoside action. On a clinical level, digitalis use in acute myocardial infarction in man remains an important topic for future investigation.

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PAUL F. GUERIN, MD, Chairman
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Librarian

library

Behind The Screen

Upon returning to my desk one morning I found a delightful little book entitled *Behind the screen* by Dr Maurice Chideckel and presented to our library by Dr Samuel S Glick.

The author was for many years a general practitioner in East Baltimore where his wit and humor must have been quite an asset in his relationship with his patients.

The dedication for this gem reads: "To the typical American physician and scholar, John Ruhräh, M.D., author, teacher, and artist this book is dedicated with profound respect and admiration." To anyone connected with the Faculty in the early years of the century, Dr Ruhräh, a renowned pediatrician, was a gracious benefactor and friend. Now his double desk, oval table, and chairs are part of the furnishings of our reading room and which some day we hope to place in an appropriate "History of Medicine Room."

A few quotes from Dr. Chideckel's book will probably reflect his personality.

"To all the bills I mailed tonight: Many happy returns."

"I have a new cure for rheumatism," I told Mrs Esther Meyrowitz.

"It is bee poison."

"What did you say to me right this minute?"

"Bee poison," I repeated.

"Be poisoned yourself! My husband will show you how to insult a lady!"

"Told pious Spinster Woodward that her general unwell feeling is probably due to a disease called trichomonas and that it is found exclusively in virgins. 'Then I haven't got it,' she murmured and rushed out of the office."

Many longer anecdotes and stories fill the 275 pages.

He concludes with this terse statement:

"And so do I close this, my diary for one year. And if you have seen yourself mirrored in it, whose fault is that?"

(Chideckel, Maurice, MD, Baltimore. *Behind the screen*. NY American Pub Co Inc, 1933)

Regional Meetings of the Medical Library Association

The MLA Mid-Atlantic Region had its annual meeting in Charlottesville, Va, Oct 21, 1972, with the University of Virginia Medical Library as host.

The morning program included a summary of on-line retrieval systems of the National Library of Medicine by Dr Joseph Leiter, followed by a well-illustrated demonstration of indexing as accomplished at NLM by Mrs Thelma Charen of NLM's Bibliographic Services Division.

Following luncheon the meeting resumed with a motion picture, "Thomas Jefferson's academic village," and ended with a presentation showing the development of a hospital library in a 250-bed hospital in Radford Community Hospital, Radford, Va, by Dr David B Walthall III.

During the concluding business meeting an announcement was made that the 1973 meeting would be in Baltimore with Welch Medical Library as host.

On Oct 20 and 21, Mr Jensen, the Assistant Librarian, attended the Upstate New York Medical Library Association's annual meeting in Toronto. Of primary interest was a discussion and panel on the copyright issue, led by Mr Peter Grant, Barrister, in which Mr Jensen participated. There was also a long session on audiovisual material for Health Science Libraries. The meeting was well organized and most informative.

Calendar of Meetings

Jan 9, Tues—American Hospital Association regional meeting—Maryland/DC/Delaware—Washington Hilton Hotel, Washington. Hospital librarians' program sponsored by the Baltimore Hospital Librarians Association. Subject: Shock trauma for hospital librarians—etiology and suggested therapy. (Control of nonbook media and retrieval systems for special materials will be discussed.)

Jan 17, Wed—Special Libraries Association. Place, time, and subject to be announced.

Jan 18, Thurs—Baltimore Hospital Librarians Association—Place to be announced. Subject: Scales for judging adequacy of library budgets.

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ELECTROLOGIST

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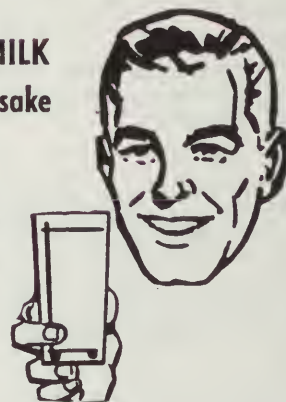
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WEDNESDAY, THURSDAY, FRIDAY, APRIL 25, 26, 27, 1973
BALTIMORE CIVIC CENTER**

Over 19 specialty and general presentations will be given during this 175th Annual Meeting of the Faculty.

MODERN TRENDS IN GERIATRIC MEDICINE will be the title of the **Jesse C Coggins Fund Lecture** given by **W Ferguson Anderson MD**, Professor of Geriatric Medicine, University Department of Geriatric Medicine of the Southern General Hospital, Glasgow, Scotland.

ISCHEMIC HEART DISEASE will be the general title for a session of which **Richard S Ross MD**, Professor of Cardiovascular Disease, The Johns Hopkins University School of Medicine, will be the moderator. The participants will be

Bertram Pitt MD, EVOLVING CONCEPTS OF MYOCARDIAL ISCHEMIA —
A BACKGROUND FOR THERAPY

C Richard Conti MD, THE SYNDROME OF UNSTABLE ANGINA PECTORIS —
A THERAPEUTIC CHALLENGE

David T Kelly MD, and **Dean R Taylor MD**, MYOCARDIAL INFARCTION —
EVALUATION OF THERAPY IN 1973

A panel discussion will follow in which all of the above will participate plus **Leonard Scherlis MD**, Professor of Medicine and Head of the Department of Cardiology, the University of Maryland School of Medicine.

THE PROBLEMS OF POLYARTHRITIS, a panel discussion moderated by **Mary Betty Stevens MD**, Associate Professor of Medicine, The Johns Hopkins University School of Medicine, will have as participants **Werner F Barth MD**, **Harry F Klinefelter MD**, **Thomas M Zizic MD**, **Gaylord L Clark Jr, MD**, and **Jack W. Bowerman MD**.

CURRENT CONCEPTS IN THE THERAPY OF CONGESTIVE HEART FAILURE, a panel discussion moderated by **William J Kinnard Jr, PhD**, Dean of the School of Pharmacy, University of Maryland, will have as participants **Robert A Kerr, PharmD**, **John Young, PhD**, and **Anthony Manoguerra, PharmD**.

SURGICAL DISEASES OF THE COLON will be discussed by **Bentley P Colcock MD**, Chairman of the Board of Governors of the American College of Surgeons and Senior Surgeon at Lahey Clinics; and **Robert J Coffey MD**, Professor of Surgery at Georgetown University School of Medicine.

WHY TREAT DIABETES will be the title of a discussion by **Marjorie Peebles-Meyers MD**.

SEXUALITY AND THE PRACTICE OF MEDICINE will be discussed by **Mary S Calderone MD**, Executive Director of SIECUS (Sex Information and Education Council of the US). This will be the **Hundley Memorial Lecture in Gynecology**.

Additional information about the speakers and subjects will be published in the Feb and March issues of this Journal. A complete program will be sent to all members of the Faculty several weeks prior to the meeting and to others upon request.

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Nicotine May Increase Susceptibility to Infection

Why do smokers have more sick days than nonsmokers?

A researcher at Georgetown University Medical Center has found that the nicotine in cigarette smoke could increase a smoker's susceptibility to illness involving the entire system, not just the lungs. It is generally known smoking increases the incidence of lung cancer, and other respiratory diseases, but is not as well known that it also increases incidence of infective diseases throughout the body.

"In the past, the reasons for these latter conditions were not clear," says Sorell L. Schwartz, MD, associate professor of pharmacology at Georgetown's schools of medicine and dentistry. "This was because many of the harmful components of tobacco smoke which affect the lungs do not get into the general circulation. However, nicotine, a major component of smoke, does enter the blood stream and distributes itself throughout the body.

"For three years we have studied the effects of nicotine on part of the reticuloendothelial system, a system responsible for the body's defense against infection. We found nicotine interferes with that system, potentially lowering the body's defenses and consequently causing an increased susceptibility to sickness among smokers."

Dr Schwartz studied the way nicotine acted on macrophages, a type of cell which plays an important role in the primary stages of immunity. Immunity is the mechanism by which the body develops resistance to foreign invaders like bacteria, viruses, and other substances which cause

infection or inflammation leading to disease. If any of its natural defenses are impaired, the body becomes more susceptible to disease.

The macrophages are present throughout the body and perform a double function. They take in and kill bacteria by "digesting" or breaking them down with various enzymes. They also process particles from any ingested foreign substance and release a portion of it as a "processed antigen." This "processed antigen" in turn stimulates other cells to produce antibodies which fight specific foreign substances and maintain immunity. The macrophages are the first step in this immune process and are essential to antibody production.

Over a three-year period, the Georgetown project studied tissue cultures of macrophages obtained from the abdominal cavities of mice. The cells were labeled with molecular tags for easy tracing, and nicotine was added to study its effects on their function.

Dr Schwartz found 1) nicotine interfered with the intake of foreign material by the macrophages, and 2) nicotine interrupted the digestive process of the cell by causing a form of cellular regurgitation.

This means nicotine can potentially interfere with the ability of cells to engulf foreign organisms and interfere with the ability of the body to adequately process antigens necessary for antibody production.

"The mechanism for this is complex," Dr Schwartz says. "We believe this occurs because nicotine decreases cell

wall availability in the macrophage for intake of material, while simultaneously increasing the opportunity of engulfed material to be released."

National Immunization Group Formed

Nine young physicians active in public health have formed a group called the Action Committee for Childhood Immunizations to fight for a long-term comprehensive national vaccination program for children.

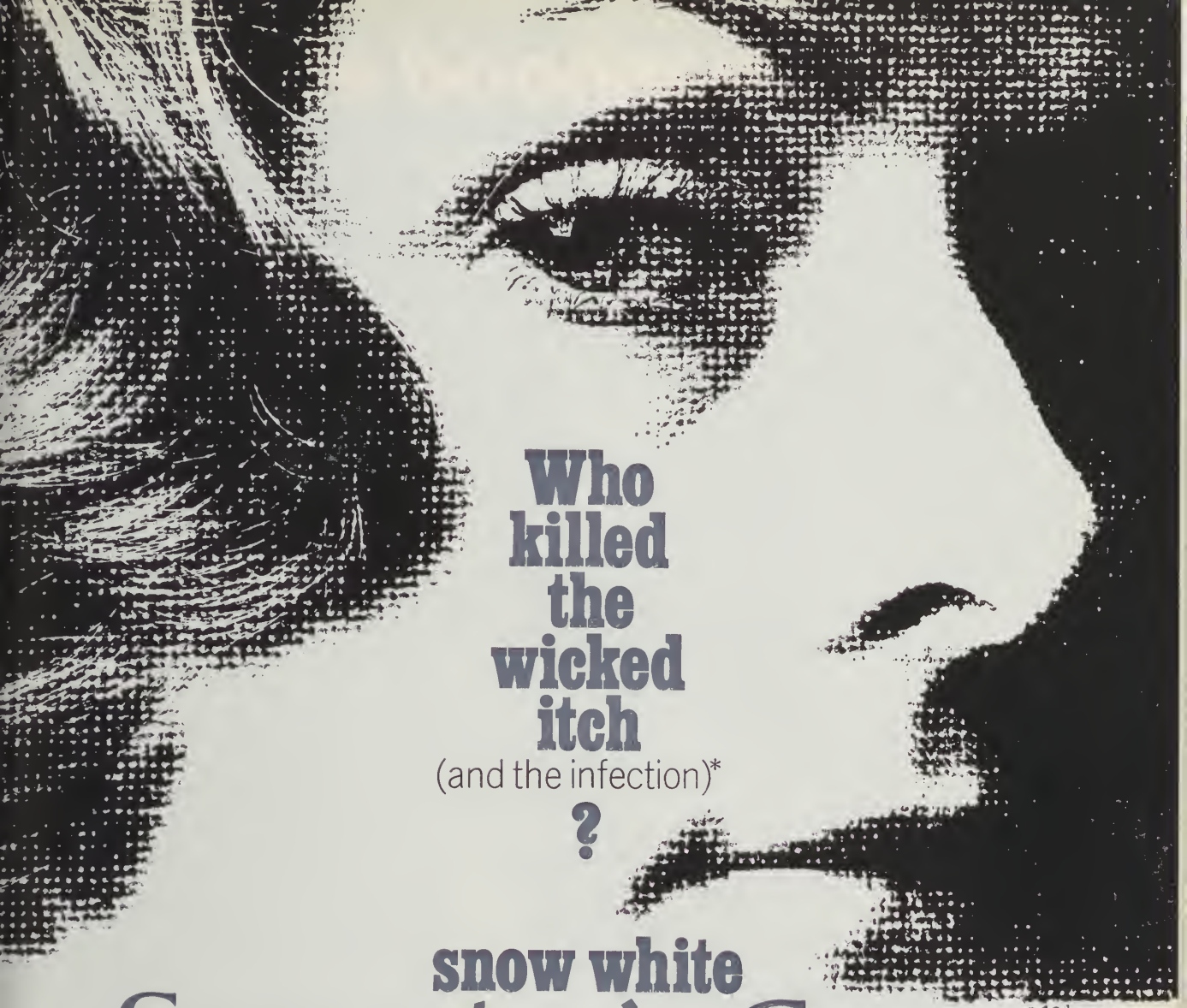
The nine doctors, former members of the US Public Health Service, includes two Marylanders.

They are John M. Neff, MD, assistant professor, Department of Pediatrics, Johns Hopkins Medical School; and Howard J. Garber, MD, MPH, in private practice in Randallstown, formerly chief, Division of Communicable Diseases, Maryland State Department of Health and Mental Hygiene.

The doctors are distressed by outbreaks of preventable diseases such as measles, polio, and diphtheria which are traced to a decline in immunization levels of preschool and school-age children.

An alarming number of parents have not had their children comprehensively protected with available vaccines. For complete protection, a child should be vaccinated against measles, polio, diphtheria, tetanus, whooping cough, rubella, and mumps the Action Committee claims.

Much of the problem can be alleviated, said the Action Committee, if there is a long-term federal funding of vaccination programs at the local level.



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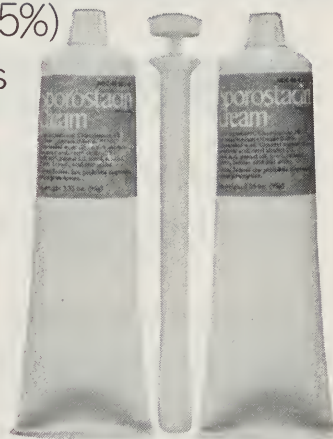
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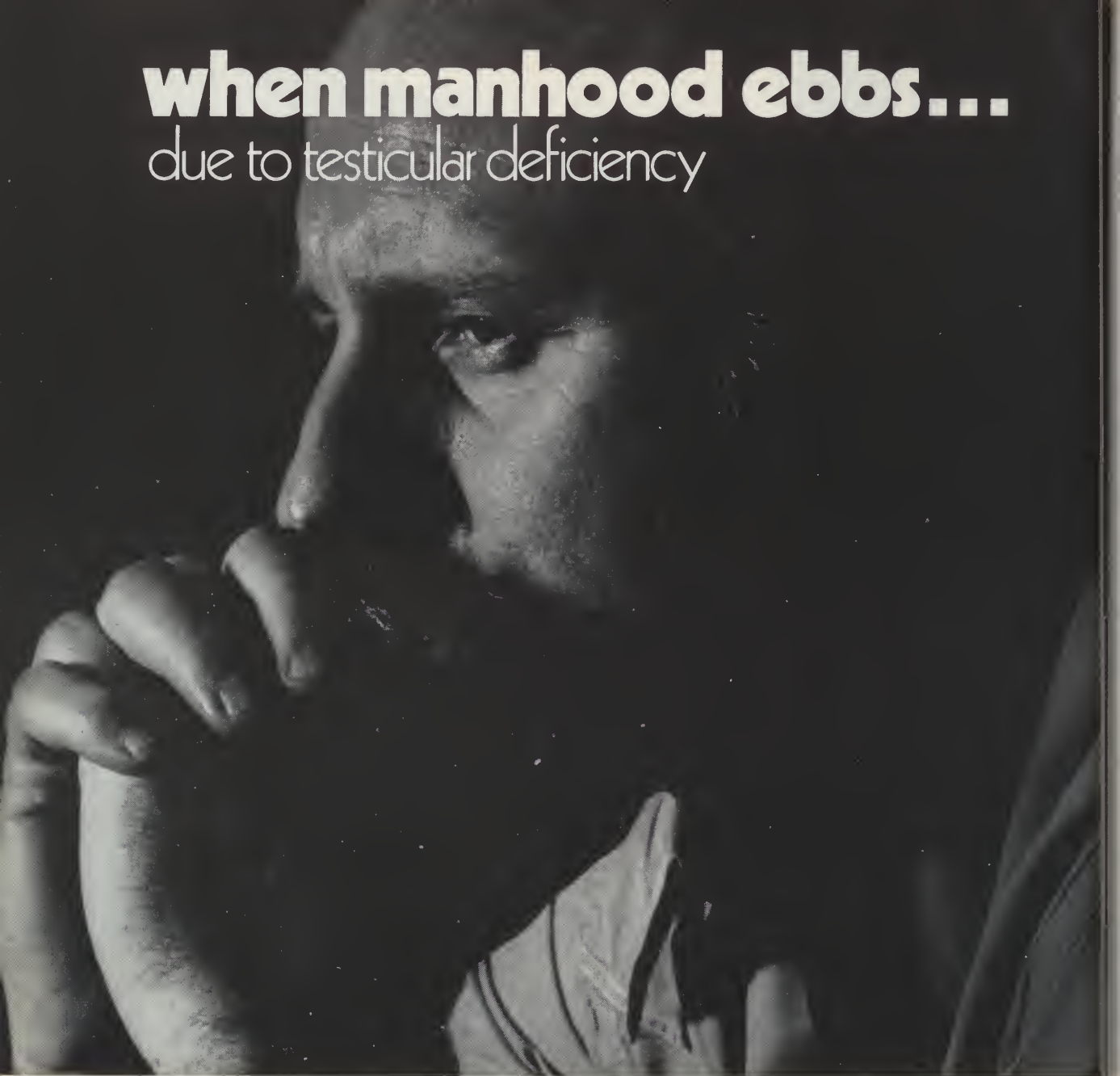
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Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water

thus forming edema. Priapism or excess stimulation, oligospermia, reduced ejaculate volume, hypersensitivity and gynecoma occur. When any of these effects appear, drug should be stopped.

Adverse Reactions: Acne. Decreased ejaculate volume. Gynecomastia. Edema. Hypercalcemia. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic carcinoma). Virilization in females. Cerebral jaundice.

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Election Postmortems

Publication delays being what they are Election Night must seem a long time ago. The results of the November 6th election are nonetheless of very lasting importance.

Your Maryland PAC would like to take this opportunity to point out the Congressional races in Maryland in which we had an interest and particularly those in which "our" candidates were successful. Physicians consist of only 1% of the national electorate. Thus, it is obvious that only by acting as a group can we have any real political influence.

In the most recent election, Congressman Mills in the First District was supported by MMPAC. In the 4th District Mrs Holt, again supported by MMPAC, was the successful candidate. Congressmen Hogan, 5th District; Byron, 6th District; and Gude, 8th District, were all supported by MMPAC and were all reelected.

Naturally, we are pleased with these election results, and we hope that you, too, are pleased. What must be kept in mind, however, is that your interest in political activity must not be limited to election time. Now that Congress is once again in session many pieces of legislation are or will be considered which have a bearing on the nation's health.

Be sure to read such periodicals as the *American Medical News* and *Medical Economics* to inform yourself about current legislation. Make an informed decision about legislation, and, most important of all, make sure YOUR Congressman knows how you feel. Members of Congress sincerely try to vote the way they think their constituents want.

To do so they obviously must be informed by you.

When you communicate with your Congressman, do so in a friendly but businesslike way. Be factual and knowledgeable. Use exact bill numbers and popular titles. Subordinate your self-interest and do not write in a belligerent manner.

Sign your name plainly and type your name under your signature. A letter is far better than a telegram, and keep to one subject per letter. Remember, you can speak only for yourself, not for the profession as a whole. Very little attention is paid to mimeographed or form letters. ALWAYS be courteous; Congressmen enjoy being treated politely as much as you do.

The decade of the 1970s is a very important one for medicine. Some form of health-care-delivery legislation is almost a certainty in this Congress. The medical profession must remember that politics is people working together to solve problems. Politics is the art of government. The decisions of government affect all of us; therefore, we should all play an active role in politics.

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FREDERICK J. BALSAM, MD, Editor

rehabilitation medicine

OSTEOPOROSIS

CLARA J FLEISCHER MD

Associate, Department of Rehabilitation Medicine

Sinai Hospital of Baltimore

Associate Professor, University of Maryland School of Medicine
Baltimore

Information and reprint requests to Dr Fleischer at Sinai, Belvedere and Greenspring, Baltimore, Md 21215.

Physicians frequently encounter the frustrating experience of not being able to help patients with constant complaints of backache and of aching bones and joints. This is particularly true today as we see more and more elderly people readily availing themselves of medical aid. The most common causes of these aches and pains are osteoarthritis and osteoporosis. Pains due to osteoarthritis are generally recognized, but there is a tendency to ignore the osteoporosis. Yet it probably is osteoporosis that is the cause of many aches as well as the cause of minor or major fractures. A common clinical sequence is osteoporosis, fractured hip, nursing home, pneumonia, and death.

What is osteoporosis? By definition, osteoporosis means diminution of bone density. A so-called physiological form of osteoporosis means a reduction of bone mass with aging. A truly pathological form of osteoporosis is characterized by osteonecrosis, vertebral collapse, and eventually compression fractures.

Paradoxically, on one hand, we have an increase of bone mass with advancing age and accretion of apposed bone. On the other, we also have a decrease in bone density. This is particularly true in women, and it is accelerated in the postmenopausal period. Although we say that osteoporosis is, to a degree, a physiological change, there are some differences between the various forms of osteoporotic disorders.

In osteoporosis, we have a primary derangement of protein metabolism and closely associated metabolic activities which influence calcium

conservation. The elderly consume about 20-30% less calcium in their diet, and they absorb a smaller fraction of the ingested calcium. They fail to achieve a balance between intake and output. The elderly excrete the primary calcium normally, but fail to retain the circulating calcium and absorb it at a much lower rate. In addition, they have a much lower circulating Vitamin D level. Alteration in excretion pattern of steroid metabolites suggests a deficiency of secretion of androgen relative to corticosteroids.

The etiology of osteoporosis is basically unknown. There are a number of observations which suggest some reasons for diminished calcium:

1) Menopause—A postclimacteric state in which a decrease of estrogen and androgen is noted. This does not completely answer the question of rapid calcium and phosphorus loss which is detectable by routine laboratory tests at menopause.

2) Dietary deficiency of calcium and phosphorus due to inadequate intake of these substances and a decrease in Vitamin D and C intake is also blamed.

3) Increase in catabolic hormones.

4) Decrease of bone formation rate.

5) More likely, increase in bone resorption which exceeds bone formation results in reduced bone density. In this state the calcium turnover, the total skeletal accretion, and loss of calcium from the skeleton are normal in relation to body weight, but increased in relation to the skeletal mass. The bone resorption is increased and the rate of cellular activity on apposed surfaces is reduced.

6) Possible aberration of the effect of thyrocalcitonin.

7) Possible aberration of the effect of growth hormone.

8) Possible effect of parathyroid hormone.

Classification of Osteoporosis

1) Congenital loss of bone density or osteogenesis imperfecta.

2) Osteoporosis due to inadequate muscle activity such as is seen during immobilization due to a paralysis or in astronauts.

3) Degenerative form seen in senile osteoporosis.

4) Nutritional osteoporosis caused by malnutrition and loss of proteins, Vitamin C and Vitamin D deficiency.

5) Endocrine osteoporosis as a result of estrogen deficiency seen in the postmenopausal state or due to ovarian agenesis. Androgen deficiency seen in eunuchs and in senility. Also in excessive production of corticosteroids (Cushing's syndrome) or iatrogenically produced by administration of ACTH or corticosteroids. Hyperthyroidism, hypothyroidism, acromegaly and panhypopituitarism also produce osteoporosis.

6) Idiopathic osteoporosis.

Clinical Manifestations

Osteoporosis in adults is usually a slowly progressive condition and it usually becomes evident in the postclimacteric period with the following complaints: a girdle-like pain originating in the vertebral column even before fractures are demonstrated. The pain may also be a burning, paraesthetic type, not necessarily along the anatomical distribution of any nerves.

The principal manifestations are vertebral compressions with resulting kyphosis and loss of vertical height. The lumbar vertebrae may show biconcave depression, the so-called Albright's codfish-tail vertebrae. These compression fractures may be asymptomatic; but when vertebral collapse occurs, the patient develops an exaggerated kyphosis with downward angulation of the ribs. The ribs actually "ride" over the pelvic brim. When this occurs, the patient may experience some severe flank pain. Sometimes this pain can be reduced by physical therapy, postural correction, and appropriate bracing. However, when it is very severe, it may require excision of the lower costal cartilages and a hyperextension brace.

The other areas of stress that are very vulnerable to fractures are the hips, the proximal end of the femur, the distal end of the radius, the

ribs, the pubic and ischial rami, and the proximal end of the humerus.

Laboratory findings are nonspecific. The plasma calcium, phosphorus, and alkaline phosphatase may be normal or near normal. In some women with low protein intake, the serum calcium may be low. Bone biopsy reveals only thinning of the cortex and attenuation and fragmentation of the trabeculi. Bone biopsy is not specific in osteoporosis, but may be of value in making a differential diagnosis because it helps to exclude some pathological disorders resembling osteoporosis.

The X-ray findings reveal a loss of trabeculation, progressive cortical thinning, and microfractures, biconcave compression of the vertebral bodies, particularly in the lower thoracic spine, and wedging of the thoracic vertebrae with kyphotic deformity. Fractures of long bones may be seen at the metaphysis, such as at the distal end of the radius, the proximal portion of the femur, and in the ribs. Sometimes these may be asymptomatic. In elderly people, these fractures pose some difficulty when fixation is attempted. The bone is so osteoporotic that pins and plates may not stay in place. At times, even a prosthetic replacement is not successful because of marked medullary cavitation of the long bone shaft.

Pathology

There is an overall trabecular and cortical resorption, the so-called "moth-eaten spongy bone."

Differential Diagnosis

Diseases that present gross evidence of osteoporosis of the bones are Cushing's syndrome, multiple myeloma, hyperparathyroidism, and metastatic malignancies. Osteomalacia does not cause diffuse skeletal atrophy, and it does not present the same clinical and X-ray picture as osteoporosis. Osteoporosis in Cushing's disease is associated with marked depression of osteoblast activity and defective healing of fractures. Similar findings occur in osteoporosis as a result of steroid therapy; however, here the alkaline phosphatase is low. The urine calcium is usually moderately elevated and the gastrointestinal calcium absorption is depressed. In hyperparathyroidism the bone turnover is accelerated. In some patients, bone resorption may exceed bone formation sufficiently to produce significant osteoporosis. The plasma calcium, phosphorus, and alkaline phosphatase may be high. This type of osteoporosis is reversible when the disease is recognized and corrected. Multiple myeloma can be ruled out by bone biopsy and examination

of the marrow as well as electrophoretic separation of the plasma proteins and a positive Bence-Jones protein in the urine. Metastatic malignancy may present a differential problem when it causes vertebral compression fracture. Usually, bone survey will demonstrate other areas where metastatic lesions are present.

Disuse osteoporosis is a local disorder which is confined to bones or regions that have been immobilized and deprived of normal muscle pull. In polio or Guillain-Barre syndrome, the entire skeleton may be involved; unlike physiological osteoporosis, the spine is less involved. There is massive bone resorption as a result of withdrawal of mechanical stresses; basically, the picture is the same as osteoporosis of aged and menopausal patients. Similar problems of resorption occur in weightlessness, as seen in astronauts, due to lack of mechanical stress. The calcium loss in the urine may be as high as 800 mg per day. If they are not sufficiently hydrated and high urinary flow is not maintained, glomerular filtration falls and hypercalciuria may result.

Nutritional osteoporosis results from nutritional deficiency syndrome in patients of all ages. Usually, general calorie and protein intake are low. Examples include kwashiorkor, scurvy, or chronic alcoholism. This form of osteoporosis is reversible and can be corrected with an appropriate nutritional intake.

Idiopathic osteoporosis is a term applied to young men and women in whom there is no demonstrable cause for osteoporosis. It is very similar to menopausal osteoporosis. The cause is unknown. It tends to stabilize with time, and the only effective treatment is exercise.

Reflex sympathetic dystrophy or Sudeck's atrophy will also display a picture of osteoporosis. It usually occurs following a fracture or other minor injury; oddly enough, the osteoporosis occurs in an adjacent bone. It is usually associated with severe pain, swelling, tenderness, and sweating. Sympathetic block may relieve the symptoms. Again, intensive physical therapy with mobilization and muscle activity may correct this type of osteoporosis.

Treatment

In the 1930s and 1940s, a combination of estrogen and androgen was recommended in senile osteoporosis and postmenopausal osteoporosis. In time, fear of possible carcinogenic effect reduced their use by the medical profession. However, if given with caution and the patient is carefully observed, small doses, in a combination therapy with minerals and vitamins, are gener-

ally considered safe. The rationale for using this form of therapy is as follows:

The estrogens are given because they are effective in stimulation of bone formation. Androgens are necessary to maintain a positive nitrogen balance and because they have a bone-stimulating effect. They stimulate increase of muscle mass and a general feeling of well-being. However, in addition to the estrogen and androgen, one also must provide a high protein intake to make material available for the bone matrix formation. Large doses of Vitamin C are necessary to stimulate osteoid formation; Vitamin D to aid in the transport of minerals across the intestinal wall and aid in deposition of mineral in the bone; and calcium and phosphorus to provide the necessary mineral content. Consequently, some combination of these drugs given for prolonged periods may be beneficial. Of course, none of this medication can provide the necessary metabolic adjustment in a short time. Theoretically, this should be started in the premenopausal period to prevent osteoporosis, and should be continued over a long period—perhaps indefinitely. This may not prevent onset of symptoms. However, when symptoms occur, there is relief of pain and a sense of well-being after prolonged and adequate therapy. This may occur without marked increase in bone density.

In severe osteoporosis, perfusion therapy with calcium has been tried by Pak and his associates at the Bethesda Naval Research Center with some good results, but it has not been sufficiently tested to make it a common procedure. However, it is worthwhile to keep in mind in cases where all other forms of therapy fail. In addition, a carefully selected and appropriate diet is of great importance. One must make sure that patients have adequate meat and seafood intake, that they get plenty of fresh fruits and fruit juices, that they include appropriate dairy products such as three or more glasses of skim milk or buttermilk a day, and one serving of cottage cheese and ample green vegetables. It is not sufficient merely to enumerate to the patient what he should eat, in the hope that he will understand what is required.

If one scrutinizes the diets of the elderly, it will be found that they are generally high in starches and fat and very poor in essential minerals. One would think the elderly would be more cautious about their diets. Unfortunately, the majority of them live by themselves or in institutions; although the food is plentiful, the diet is frequently most inappropriate. Drugs such as propoxy-pitene hydrochloride (Darvon) or aspirin may

give some measure of immediate relief; however, narcotics and steroids should never be used. Physical therapy is very helpful. Moist heat and, whenever available, some form of bath such as Hubbard tank or warm pools are very beneficial and do relieve the acute pain while allowing the patient to mobilize and exercise the extremities. Of course, when taken as tub baths at home they should be under very close supervision or assistance by a member of the household, as accidents may occur if elderly patients take tub baths by themselves. It is also not sufficient to tell the patient to take hot or even warm tub baths, since some of these patients may have impaired circulation, and the temperature of the water must be carefully prescribed. Gentle massage will stimulate circulation and also provide some analgesia and muscle relaxation.

In cases where there is persistent intercostal pain, some form of local anaesthetic may be beneficial in addition to the above enumerated therapy. Nerve blocks are necessary at times, but simple topical anaesthetics such as Fluro-Ethyl spray massage (Gebauer) or procaine by iontophoresis may relieve the local pain. If pain occurs in weight-bearing joints, one must relieve the stress of walking on these joints and particularly prevent stress fractures in the areas that are most vulnerable, such as the hips. Consequently, canes or Lofstrand crutches will relieve the weight-bearing stress and relieve some of the pain. For compression fractures in the lumbosacral spine or even pain in that area, a well-fitted, well-padded corset with heavy stays may give adequate support. Here again, it is not enough to simply prescribe a corset, but the doctor must check it out to make sure that it is appropriate. Spontaneous fractures are most common in the lower thoracic area of the spine. A light-weight corset with heavy stays in the back and an added "Taylor insert" molded to the kyphotic configuration of the thoracic spine is well tolerated by the patient and may afford support and give some relief of pain. Heavier bracing, however, is not recommended. Although, logically, hyperextension supports are the braces of choice, they are not well tolerated by patients and, when prescribed, are usually not used.

Because of severe pain, patients have a tendency to limit their activity. They remain in bed for prolonged periods which only fosters further osteoporosis. This is definitely contraindicated. Every effort should be made to get the patient mobilized, walking if possible. Graded general conditioning exercises and muscle strengthening, as mentioned previously, aid in producing an in-

crease in muscle bulk. Not only do the muscles splint a porous bone, but stress of muscle pull aids in deposition of calcium in the bone. However, patients must be cautioned to avoid excessive muscle strain because muscle splinting or spasms may produce fractures in the areas where the muscles are attached.

Secondly, the patient must be instructed in modifying his home environment. We find that many elderly have cluttered rooms. They move all their possessions into areas much smaller than those in which they were accustomed to live. These cluttered rooms foster accidents. The bathrooms are not equipped with railings on the tubs and toilets. They should be advised to have simple tub railings, which can be purchased in the housewares section of a department store and installed on the bathtub without major expense. These railings should provide the patient with adequate support without his having to grasp a towel rack or other unsafe object. Appropriate railings installed over and alongside the toilet seat would not only give the patient a confined safe area, but would also aid him in getting up from the toilet. The most common accidents occur during such a procedure when the patient is not strong enough, loses his balance, and falls backwards, striking some part of his body against a tub or sink.

One must also caution the patient against using any scatter-rugs. Since the gait of the elderly is not brisk and they do not pick up their feet, the tendency is more towards a shuffling type of gait which can cause slipping of the rugs. The patient must also be cautioned against lifting heavy objects. During lifting, there is an increase of the intra-thoracic and intra-abdominal pressure producing an increase in intervertebral pressure which can result in spontaneous fractures.

Medical science is presently unable to offer a rapid "cure" for osteoporosis. Measures suggested for the management of this condition are more effective as preventives than as therapeutic measures. Perhaps, after adequate clinical trials, we may consider supportive use of hormones as well as calcium and phosphorus mineral replacement in the elderly as a routine supplement. Possibly, it should be started as early as the 40s and 50s at the slightest appearance of evidence of osteoporosis even though the patient may be asymptomatic. Exercise and maintenance of good muscle tone would probably prevent further development of osteoporosis in most cases.

Present-day knowledge of this disorder is lim-

ited. It is hoped that by repeatedly presenting this problem to the medical profession at large, more scientific interest in the subject will be stimulated so that we will eventually have a better understanding of pathogenesis, preventive and more effective therapeutic approaches, and, perhaps, even measures that will reverse the process.

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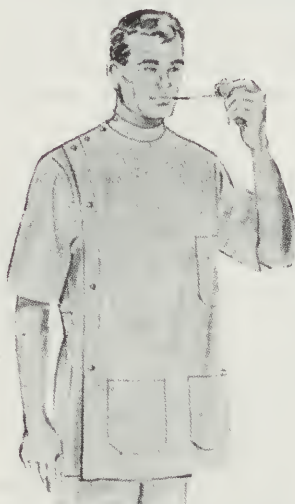
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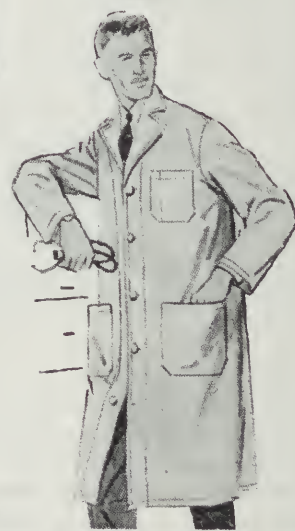
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The Hiring and Employment of the Handicapped and His Rehabilitation

HERMAN J HALPERIN MD
1940 W Northern Parkway
Baltimore, Md 21209

Information and reprint requests to Dr Halperin at 1211 Cathedral St, Baltimore, Md 21201.

No one is without limitations. The difference between people is only in the degree of ability and not disability. For the most part, handicapped people are quite capable of doing a good job in industry. Let's face the fact that there are very few of us who are not handicapped in some respect. While some of us may have a physical impairment, others may have a deficiency of experience, or a personality disorder, or an emotional or mental condition that hinders the performance required by employers.

Many reasons have been given for and against the hiring of workers with physical and mental disabilities or impairments:¹

Reasons for Hiring

- 1) They are better than normal workers.
- 2) They are less likely to quit.
- 3) They have a better attendance record.
- 4) They are more conscientious.
- 5) They try to (or do) work harder.
- 6) They are as good as any normal worker.
- 7) They are loyal.
- 8) They are less accident prone.
- 9) They have fewer health problems.
- 10) They are reliable.
- 11) They gossip and fool less.
- 12) It is good public relations.
- 13) It is a civic duty.
- 14) Labor shortage.
- 15) They appreciate their jobs more.
- 16) They have greater skills and are more knowledgeable.
- 17) They are always on time.

- 18) They are always motivated to prove themselves.

Reasons Against Hiring

- 1) It makes for bad public and plant relations.
- 2) They are not as good as normal workers.
- 3) They need more sick leave; that is, they are absent more.
- 4) Coworkers are negatively affected.
- 5) They are unable to work promptly.
- 6) It is an accident risk.
- 7) They have emotional problems.
- 8) It is hard to fire them (either because of union or pity).
- 9) They are not promotable.
- 10) They need special hours.
- 11) Poor mobility.
- 12) Transportation difficulties to and from work.
- 13) They are not versatile.
- 14) The labor market is better.

Thus it seems that there is no single reason or combination of reasons that appear to be consistently important in shaping the attitudes and policies of personnel officers, either FOR or AGAINST the employment of workers with disabilities.

The American Medical Association, House of Delegates, June 1962, adopted the following resolutions on employment of the handicapped:²

Whereas, Many thousands of industrious American people are handicapped for permanent partial impairments of health and bodily function as a result of congenital defects, injury, and disease; and

Whereas, Many handicapped persons retain capacities for performing tasks equal to the nonhandicapped and many more can be rehabilitated, including occupational training in new skills; and

Whereas, In the past, employers have often not fully been aware that many of the handicapped have better health, safety and work records than other employees; and

Whereas, The medical profession had repeatedly demonstrated that many of the permanently handicapped people

can perform safely and productively if appropriate attention is given to their selective placement in jobs suited to those skills and capacities that remain or can be developed despite their handicap; now therefore be it

Resolved, That the American Medical Association supports the principle that each individual candidate for employment should be evaluated in light of his ability to perform useful work, and be it further

Resolved, That the American Medical Association recognizes that handicapped people when placed in positions for which they are qualified, make efficient, loyal, dependable employees.

Role of the Employer

An employer seeks to hire people who are able to work capably and safely. He attempts to hire people who will be good compensation insurance and group insurance risks. He hires people who are healthy and are likely to remain healthy. He doesn't wish to be held legally responsible for diseases and injuries occurring in handicapped people which may be unrelated to their employment.

Most employers realize they have a community responsibility and hire handicapped people to a limited degree. They blame their reluctance to employ these people on the restrictions placed upon them by union contracts, compensation laws, and insurance costs. They feel that they cannot be completely philanthropic; by refusing the handicapped, they make society aware of its responsibilities.

The employer feels that all jobs are necessary ones, and that the worker, regardless of his handicap, must maintain a level of productivity equal to that of his coworkers. In a large industry, the employer may make changes in a job requirement to suit the particular handicap of an employee. In a small industry, "make-work projects" reach a saturation point very quickly, so that the employer may feel personally obligated to return a certain loyal handicapped employee to some type of work when he may not follow a policy of having his employment or hiring office fill jobs with handicapped people.³

Role of the Family

The key word for the handicapped worker is motivation. Without it he will never return to his place in society. From the very moment the worker comes under medical care, the seed of rehabilitation must be planted in his subconscious. The influence, encouragement, inspiration, and persuasion of the worker's family and attending physicians will go a long way in hastening the worker's recovery and rehabilitation.

A very serious roadblock to early rehabilitation is litigation and the matter of secondary gain. "There is inherent in most of the states' compensation laws a conflict in which the injured work-

man seemingly must choose between maximizing his injury to increase monetary compensation or minimizing his injury through rehabilitation or other restorative process at the expense of diminishing or terminating his compensation. In a word, it is somewhat difficult to retain the just compensation features without impairing motivation for rehabilitation. The conflict between compensation payments and medical care and rehabilitation will always be present as long as the primary emphasis of the compensation setup is upon monetary payments. The problem is now to minimize this conflict."⁴

The family must be available from the very beginning to show love, compassion, and understanding. They must dispel the worker's fears and doubts and stimulate the worker to achieve a maximum recovery.

Role of the Family Doctor

"The primary obligation of the individual physician is to see that his patient is restored as nearly as possible to the economic and personal effectiveness which he possessed before he was disabled. This requires not only competent and impartial medical care but also that the physicians use or recommend the use of other technical skills and resources available, whether in the community or not."⁵

The family physician plays a very important role in the rehabilitation of his patients. He is in an ideal situation to make certain that his handicapped patient is properly motivated to overcome any mental or physical disability so that he can face squarely the new problems that may arise as he returns to work.

He must make proper assessments in his evaluation of a particular disability. He must not minimize his patient's disability, yet he must not exaggerate his patient's potential. Dr Francis J Borges, former Medical Director of the Work Evaluation Unit of the Heart Association of Maryland, presents a note that a family physician wrote for one of his patients:

"To Whom It May Concern: Mr X is under my care for angina pectoris. He has improved tremendously. It is quite possible that he may return to his usual duties within ten days providing special allowances are made that he does not go up and down steps or walk any distance. It is also essential that he not be subjected to extreme heat or any discomfort whatsoever. Regardless of every precaution, Mr X may again become sick at any time and is at the mercy of anyone who makes him angry as well as any exhaustion, or strenuous activity of any kind whatsoever."

Would you, as an employer, return this patient to work?

The family physician should know what role he plays in the employment and reemployment of handicapped workers. He should know the medical criteria for employment and reemployment of the handicapped. Instructions for specific conditions, such as cardiovascular disease, epilepsy, cancer, diabetes, tuberculosis, and mental illness may be obtained by writing The President's Committee on Employment of the Handicapped, Washington, DC.

Role of the Industrial Physician

The industrial physician, whether he works for a single company or whether he is an examining physician for a number of small companies, has a dual responsibility, to the employer and to the employee. He not only sees the employee for the first time when he does the initial preplacement examination, but he continues to examine and advise him throughout his working career.

Dr John Lauer, an industrial physician, summarizes the ultimate objectives of industrial medicine as follows:

1) To fit the worker to the type and quantity of work commensurate with his ability to perform without injury to himself or to his fellow worker.

2) To maintain the health of the workman through individual medical supervision and education, and through the prevention of occupational disease and injury by proper control of the work environment.

3) To restore to health and rehabilitate those workers who, in spite of the above efforts, suffer occupational disease or injury.

4) To aid in restoring to employment the workman who suffers from nonwork-connected injury or disease.

The Industrial Medical Association outlines four basic principles which assure success in employment of disabled persons:

1) The worker should have the ability to accomplish the task efficiently; ie, be able to meet the physical demands of the job.

2) The worker should not be a hazard to himself; ie, the blind man at work on a dangerous, unguarded machine; the epileptic on a ladder.

3) The worker must not jeopardize the safety of others; ie, the bus driver with the kind of heart disease that is likely to result in sudden death; the worker subject to fainting spells handling a gas torch.

4) The job should not aggravate the disability of the worker; ie, the worker with arrested tuber-

culosis exposed to silica dust; the individual with skin disease exposed to skin irritants.

The industrial physician has a list of questions that must be answered before he hires a handicapped person or returns him to work:⁶

1) What are the physical tasks the patient performs?

2) At what rate does the patient work and for what periods of time?

3) What are the peak or higher levels of activity?

4) What emergencies may arise and what is the patient required to do under these circumstances?

5) What hazards exist on the job for the patient or for others? (temperature, fumes, heavy equipment, high altitude)

6) What recreational activities, hobbies, organizational work, etc, does patient undertake?

7) How well trained and physically proficient is the patient in the performance of his work?

8) What is the patient's emotional attitude toward his work?

9) What is the patient's motivation to work? Are there special financial considerations regarding medical expense, compensation claims, pensions, etc?

10) What is the employer's attitude toward rehiring the patient? How flexible are the physical demands of the job?

11) Does reassignment raise questions of union jurisdiction, seniority loss, or pay rate problems?

12) What other job prospects does the patient have? Does he have other training or work experience?

13) What resources are available for rehabilitation and training?

Continued liaison between the industrial physician, the disabled worker, his family, his physicians, the educational and vocational facilities, and the definitive rehabilitative establishments will assure a high level of morale and adjustment; and the maintenance of a fusion of all of the ingredients necessary for the continued employment of the handicapped.

Role of Workmen's Compensation Commissions and the Courts

When Workmen's Compensation legislation was enacted in 1911, it was concerned mainly with payment of cash benefits to the injured worker, his rehabilitation, and his return to work. Legislation that followed made it difficult, if not impossible, for the administrators of these laws to carry out effectively the natural process of injury, treatment, compensation, rehabilitation,

and return to work. Because arbitrators had to distinguish between those injuries which arose out of and in the course of employment and those which arose from the other causes, because of the differences in opinion in determining the nature and extent of a disability, because of the problems inherent in assuring and insuring financial liability, the main goal of rehabilitation was lost sight of or minimized.

Because administrators are faced with contested cases, Workmen's Compensation Commissions become courts of law and are often conducted like major criminal or civil trials. Lawyer is pitted against lawyer. Management and union come to blows. The worker is forced to don the cloak of the thespian to make an appropriate display of his disability. The laws which were passed to see that the worker received prompt and proper medical care and adequate definitive rehabilitation have given way to the abandonment of administrative responsibilities.

In 1962 representatives of various groups interested in rehabilitation, such as the National Institutes on Rehabilitation and Health Services, the Vocational Rehabilitation Administration, the Group Health Association of America, the International Association of Industrial Accident Boards and Commissions, and the National Rehabilitation Association came together at the University of Michigan to discuss the various problems connected with the rehabilitation of the sick and injured worker.

The following recommendations were made at the various workshops and were adopted by the Institute (as the conference was known):⁵

1) Workmen's compensation agencies should assume the positive obligation of administering all phases of the workmen's compensation program. This should include the disseminating of information about the program, supervising claim settlements, hearing contested claims, and supervising medical and rehabilitation services.

2) Workmen's compensation agencies should fully inform the injured worker of his rights under the law, including his rights to rehabilitation services.

3) Workmen's compensation agencies should establish an effective procedure for reporting work injuries and occupational disease. This should include prompt and adequate reporting by employers, carriers, and physicians, with follow-up reports at short intervals.

4) Workmen's compensation agencies should require and compile adequate records and statistics which should include data on medical care and other service benefits. These data should be published periodically. The development and

presentation of these statistics should follow standardized patterns so that data will be combined into national totals.

5) Workmen's compensation agencies should establish rehabilitation units consisting of medical and other qualified rehabilitation personnel. These units should be charged with the responsibility of screening medical reports and acting as liaison with all agencies and resources concerned with rehabilitation to ensure appropriate and expeditious referral when indicated.

6) Seminars and other public information methods should be utilized in order to inform physicians, lawyers, management, unions, carriers, etc more fully of rehabilitation services available. Steps should be taken to encourage them to work more closely with appropriate rehabilitation for claimants.

7) Continuing efforts should be made to achieve professional status for workmen's compensation administrators. Professional personnel should be hired only on the basis of their technical and professional qualifications. They should enjoy tenure of service and not be subject to arbitrary dismissal for reasons unconnected with the performance of their duties.

8) Sufficient funds should be provided to enable workmen's compensation agencies to supervise medical and rehabilitation programs adequately.

Because workmen's compensation commissions have been lax in protecting and supervising the worker, a litigious atmosphere pervades many of the hearings. The worker is forced to turn to an attorney to make certain that he gets everything due him under the statute. It is not unusual for a commissioner to advise a worker who is not represented to seek counsel, thereby making litigation a barrier to rehabilitation. Litigation forces medical care to be forensic, rather than clinical. It encourages the worker to magnify his disability so that he can obtain the largest possible monetary award. It widens the gap between employer and employee, militating against hiring and/or reemployment.

Another barrier to rehabilitation concerns itself with attorneys and their fees. The attorney should remember that it is the worker who is ultimately involved in medical care and rehabilitation. Their fees should be calculated to ensure the worker adequate funds to cover the whole process of rehabilitation.

Lump-sum settlement is another deterrent to rehabilitation. The worker becomes so preoccupied with the money that he is going to receive that he shelves the need for rehabilitation.

In some cases, the worker is not protected if complications arise at some later date. Workmen's compensation commissions should be charged with the responsibility to see that all workers are protected and that the rehabilitative process is not neglected when lump-sum settlements are made.

In some jurisdictions, statutory limitations are a barrier to rehabilitation. The law provides a definite time limit within which claims for compensation benefits may be filed. Whatever limitations are imposed by law, they should not begin to run until the employee has knowledge of his occupational illness or injury and its relation to his job, and until after disablement.

Subsequent injury funds have been established to help the handicapped worker return to gainful employment. Theoretically, it protects the employer if an employee reinjures himself or aggravates a preexisting condition. But they may become barriers to employment when there is lack of knowledge on the part of the employer and when there is insufficient and inadequate coverage.

Role of Vocational Rehabilitation

The Division of Vocational Rehabilitation of the Maryland State Department of Education is the official state agency responsible for providing services necessary for rendering disabled individuals fit to engage in remunerative occupations. It is charged with the responsibility to give any worker who has a physical, mental, or emotional disability all the help he needs to return to gainful employment. The services provided by the Division are:

1) Medical, psychiatric, and psychological examinations necessary for determining eligibility, the extent of disability, possible hidden or "secondary" disabilities, and work capacity.

2) Vocational diagnosis, which includes a study of the personal and social history, work experience, educational background, interests, abilities, aptitudes, and personality characteristics of the individual.

3) Individual counseling and guidance to determine the services required to meet the needs of the individual, to assist him in selecting a suitable field in which to work, and to develop a plan for providing the services necessary to attain the employment objective.

4) Hospitalization, medical, surgical, and psychiatric services as needed to correct or modify, within a reasonable length of time, a disability which is a substantial handicap to employment.

5) Physical, occupational, speech, and hearing therapy as a part of treatment when needed.

6) Prosthetic appliances such as limbs, hearing aids, trusses, braces, eyeglasses, wheel chairs, and similar devices needed to increase work ability and/or obtain or retain employment.

7) Training in interpersonal skills necessary to meet the requirements for employment, development of proper work habits, and changing personal attitudes which interfere with vocational adjustment.

8) Scholarships to professional, business, trade, and vocational schools, etc which teach the skills necessary to qualify for the selected job objective.

9) Maintenance and transportation, if necessary, during treatment and/or training.

10) Training supplies, occupational tools, equipment, and licenses as necessary.

11) Placement in employment, including self-employment, to afford the best use of abilities and skills within the individual's limitations and with due regard to preventing further injuries.

12) Follow-up after placement to ensure that the rehabilitated worker has adjusted to his job to his own satisfaction and to that of his employer.

Role of the Union

Unions were created to protect the rights of the working man. They are charged with the responsibility to see that their members receive all the rights and privileges accorded them by labor acts and agreements and employer-union negotiations. The union is involved in seniority rules, the health and welfare of the worker, and proper engineering and safety methods. The problem arises when a disabled worker who is in a certain seniority position cannot be returned to that position because of health and safety factors. Perhaps the union and management can get together and make exceptions to certain seniority rights to permit the disabled worker to return to some type of gainful employment.

Role of the Social Security Administration

Under the Social Security Act, a disabled worker, who cannot work because of a disability, is protected. Social Security defines disability for its purposes as the inability to engage in any substantial gainful activity by reason of an impairment that is expected to continue indefinitely (not less than 12 months continuously) or result in death. This covers not only his usual work but also any type of gainful employment.

The Division of Vocational Rehabilitation on the state level is the agency the disabled worker is referred to by the Social Security Administration. The responsibilities of the state agency were

described earlier. The disabled worker is observed on the job. If he continues to work for 12 months, Social Security benefits stop if he has demonstrated that he can engage in substantial gainful activity.⁷

Here again, motivation is the key factor. Experience has shown that about 35% of disabled persons return to substantial work. It has also shown that when a worker returned to his predisability employer, the probability of a successful work attempt was markedly higher.⁸

In conclusion, certain facts and recommendations must be considered if disabled workers are to be rehabilitated:

- 1) The disabled worker can and must work.
- 2) Litigation is a barrier to employment.
- 3) Workmen's compensation and social insurance laws must be reevaluated to assure the disabled worker of a decent income while undergoing rehabilitation.
- 4) The employer must be assured that he will be responsible only for that part of a disabling condition that arises while the worker is employed by him. Subsequent- or second-injury funds must be enlarged and broadened to cover any disabilities the employer is not responsible for.
- 5) Rehabilitation forces within the Workmen's Compensation Commission must be given greater priority and responsibility. There must be great-

er communication between workmen's compensation authorities and vocational rehabilitation centers.

6) All parties concerned (those mentioned in this paper) must be better educated to ensure that their responsibilities and efforts are properly coordinated and channeled in one direction only—the eventual hiring and employment of the handicapped worker.

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Baltimore City health department

VD Gonorrhea Study

An extensive study of the factors contributing to the prevalence of gonorrhea in Baltimore by the City Health Department's Division of Venereal Diseases may point the way to future reduction of the case rate of this disease in the city. The high incidence of gonorrhea in Baltimore is shown by 11,003 cases reported for last year.

The gonorrhea study, part of a federal research project conducted in several large cities, sought three major objectives: 1) to test the validity of the claim that there is a hidden reservoir of gonorrhea in women and to suggest how to overcome this obstacle to reducing gonorrhea cases; 2) to test the accuracy of present clinical and laboratory methods of diagnosis; and 3) to find improved ways of treating gonococcal organisms that are showing increasing resistance to antibiotics.

To obtain information on the first objective, data was gathered on 55,000 women patients in 20 local medical facilities. As expected, the city's three VD clinics found 25% of all asymptomatic women referred as suspects as positive for gonorrhea. In 17 cooperative clinics, where patients came for medical examinations for conditions other than venereal disease, the infection rate was also high. City Health Department family planning and maternity clinics showed 11% of females infected; hospital outpatients clinics revealed gonorrhea in about 8% of the women; and private groups and clinics, such as those sponsored by the Planned Parenthood Association of Maryland, showed 6% of the women had unsuspected gonorrhea.

These figures indicate that a sizable proportion of women have a symptomatic gonorrheal infection. Furthermore, it becomes obvious that many women who are unaware they have the disease can be detected by routine screening for gonorrhea in private physicians' offices and in clinics serving women patients. Carriers can thus

be treated early and be removed as potential sources of infection.

In approaching the second objective, related to the accuracy of laboratory diagnosis, a field study of over 1,400 female patients demonstrated that the currently approved plate culture method of diagnosis, generally used only in the laboratory, had less likelihood of specimen contamination, fewer "false positive" readings, and is a far more accurate diagnostic tool in finding gonorrhea than other media tested. Furthermore, the laboratory diagnostic study demonstrated that 60% of the females with cervical gonorrhea also had rectal gonorrhea, while 9% of the total checked had a rectal infection only. The latter cases might easily have gone undetected unless cultures had been made from both sites. This finding dramatizes the importance of physicians doing rectal screening cultures in order to effectively find all female gonorrhea patients.

In examining the problem of antibiotic resistance and how best to treat the disease, it was found that the action of penicillin, still the drug of choice in treatment, could be enhanced by probenecid given at the time of injection. Failure rates were cut in both women and men, the former from 13% to 9% and the latter from 24% to 16%. This procedure is now recommended by the US Public Health Service.

The Baltimore City gonorrhea study was presented by Ralph G Bennett MD, a Public Health Service physician, at the recent International Congress of Dermatology at Venice, Italy.

Baltimore City's venereal disease control work is under the direction of Allan S Moodie MD, Director of the City Health Department's Bureau of Communicable Diseases. Clinical Director is E Walter Shervington MD. Physicians may obtain consultative medical and epidemiological assistance in relation to their VD cases by calling 752-2000, ext 2565.

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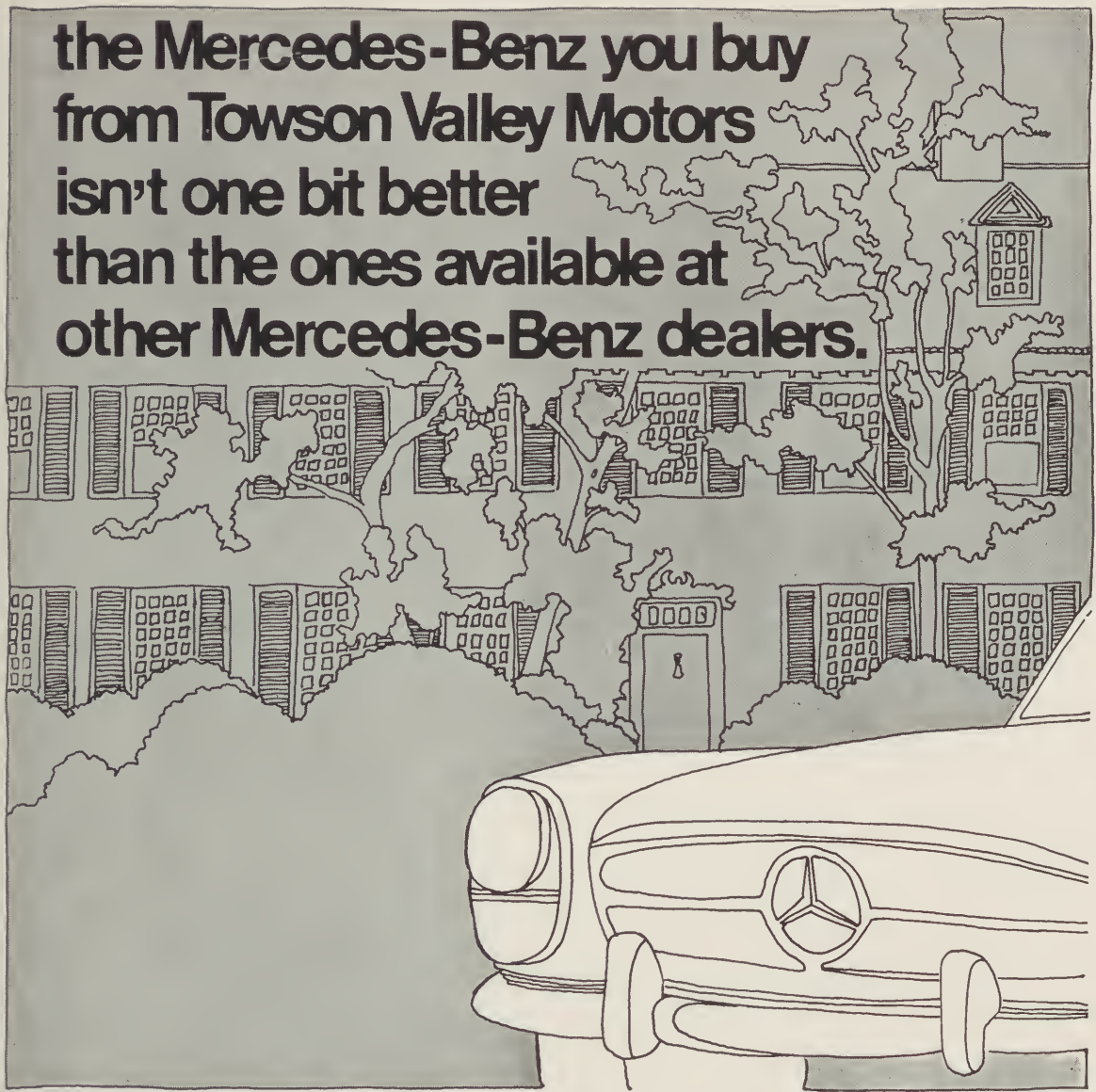
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tated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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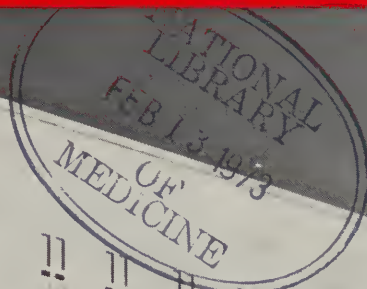
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**by John Sargeant,
Executive Director**

The Executive Committee met on Thursday, Dec 14, 1972 and took the following actions:

1. Approved a specific budget request for educational funds for activities of the Committee on Continuing Medical Education. This will be included in the budget for the calendar year 1973.
2. Determined that the 1973 budget will be discussed at the Jan 11 Executive Committee meeting, and that component society presidents will be invited to attend this budget session so they are aware of Faculty financial matters.
3. Made various recommendations for presentation to the Council in connection with nominations to the Blue Shield Board and committees of the Blue Shield Board.
4. Authorized the Executive Director to interview the son of a deceased physician and make recommendations with respect to scholarship aid.
5. Made a request to the Comprehensive Health Planning Agency in connection with its intentions with regard to the draft report on Ambulatory Care Facilities Regulations. It is understood such proposed regulations would require a "certificate of need" for three or more professionals practicing together to open an office in any area of the State.
6. Agreed to carry in the Executive Director's Newsletter a statement to the effect that a copy of an individual physician's profiles is available on written request to Maryland Blue Shield by the physician.
7. Heard a summary report in connection with activity of the Maryland Foundation for Health Care from its chairman, Manning W Alden MD.
8. Authorized the Public Relations Chairman to speak with the Regional Planning Council and the Howard County Medical Society regarding bed services at any proposed new institution in Howard County. This applies particularly to bed capacity in the regional area for Pediatric and Obstetrical services.
9. Heard a report from the Treasurer that would provide for an increase over a three-year period of the amount currently paid by the Baltimore City Dental Society for rent and services.
10. Heard that a Statewide Comprehensive Health Plan is currently under consideration for adoption by the Comprehensive Health Planning Agency and will endeavor to obtain copies for perusal and comment.
11. Declined to appoint a representative of the Faculty to serve on the Board of County Cablevision Inc until such time as it is known which organization will receive the Baltimore County cable TV franchise.
12. Deferred the question of payment of legal fees for physician's defense for a particular physician until an opinion could be obtained from legal counsel.
13. Referred to the Legislative Committee a request from the AMA for a meeting with Maryland's US Senators in connection with HMO-type legislation.
14. Adopted the following recommendation of the Committee on Preventive Medicine and Public Health:

The Medical and Chirurgical Faculty is opposed to the discontinuation of admission of intoxicated alcoholics to State Mental Hospitals, now petitioned before the Comprehensive Health Planning Agency, until such time as there are established alternate, permanent facilities available of sufficient capacity. The Faculty also strongly supports the State Mental Hospitals in their effort to create permanent shelters for the homeless or indigent inebriate and to create local permanent detoxification facilities so as to alternately return the State Mental Hospital to the care of the psychiatric patient and the alcoholic in need of psychiatric rehabilitation.
15. Approved the agreement for purchase of the Howard County land and set a date for the closing of this contract.



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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

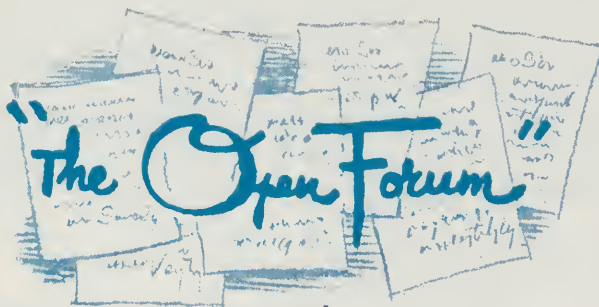
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Counterpoint to Changing Times

I am saddened to read Dr Cotter's comment (p 43, MSMJ, Oct 1972) that "attendance at meetings has dwindled," and I would like to point out the probable cause of this malady and call for reparative action.

I do not quarrel with the subjects; indeed, I applaud Dr Cotter for paying attention to socioeconomic problems. However, for a Society whose membership consists of *individual* physicians, it seems ludicrous that the podium be reserved to spokesmen of *institutions*: the State Health Department, the University of Maryland, and HMOs whereas we, the members, seem to have no spokesmen at all.

The individual physician is surrounded by regimentation at many hands; his hospital privileges are often not commensurate with his train-

ing; his fees are set by the State Health Department; his armamentarium is hampered by the Food and Drug Administration (inactive and tyrannical, most unreasonable); his very future is a political football.

If he refuses a Medicaid patient, he is a heartless ogre, to be pilloried in the papers; if he ministers to the poor and poorly paying, he is a mercenary moneygrabber, again to be pilloried in the papers.

Nevertheless, "all flowers should bloom," as Chairman Mao said, and all points of view should be heard. Unless *there is controversy* meetings bore. A speaker should be given his 15 minutes; another, opposed speaker, should have his 15 minutes; and 30 minutes should be given the audience to tear both speakers to shreds.

THIS IS THE MAGIC FORMULA FOR A GOOD MEETING, *not* the 45 *deadly* minutes allotted to the speaker, with a perfunctory 10-minute "question" period. The meat of the matter can be said in 15 minutes; the padding can be dispensed with.

I hope future presidents and program chairmen will have a chance to read this letter and profit by it.

GEORGE VASH MD
206 S Gilmor St
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CONCERNED

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MARYLAND AREA

- Mar 1-3 **Univ of Md Sch of Med**, Baltimore. Workshop on the Problem-oriented Medical Record, VA Hosp, Baltimore. 15 hrs cr AAFP & AMA. Contact: Univ Md Sch Med, Comm on Continuing Med Educ, Baltimore Md 21201, phone (301) 528-7346.
- Mar 1-April 5 **Univ of Maryland Sch of Medicine**, Baltimore. 2nd series of 6 consecutive Thursdays of selected topics in gen & family practice. Prepare for board exams or recertification. 15 hrs cr AAFP. Contact: Univ of Md Sch of Med, Comm on Continuing Med Educ, Baltimore Md 21201, 528-7346.
- Mar 5-9 **Ophthalmic Pathology**. Washington. Sponsors: ACR & AFIP. Contact: Director, Armed Forces Inst of Pathology, Washington DC 20305.
- Mar 29-31 **National Conf on Urologic Cancer**, Shoreham Hotel, Washington. No regis fee. Sponsor: Amer Cancer Society. Contact: Sidney L Arje MD, Natl Conf on Urologic Cancer, c/o ACS, 219 E 42nd St, New York NY 10017.
- Mar 29-31 **Johns Hopkins Med Institutions**, Baltimore. 1st anl symposium, Recent Advances in Diagnostic Radiology & Nuclear Medicine, Turner Auditorium. 18 hrs cr. \$175 gen fee, \$75 residents' fee. Contact: Dr Frederick P Stitik, Dept of Radiology, Johns Hopkins Hosp, Baltimore Md 21205.
- Apr 25-27 **Med-Chi 175th Anl Mtg**, Civic Center, Baltimore.
- Apr 26-28 **4th Natl Congress on Med Ethics**, Washington Hilton Hotel. Sponsor: AMA. Contact: Judicial Council, AMA, 535 N Dearborn St, Chicago Ill 60610.

AMERICAN COLLEGE OF PHYSICIANS

(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104.)

- Mar 5-8 **Problems of International Health**, Naval Hosp, San Diego, LeBaron Hotel, San Diego.
- Mar 5-8 **Modern Neurological Diagnosis & Therapy**, Univ of Miami, Edin Roc Hotel, Miami Beach.
- Mar 12-16 **Infectious Diseases**, Univ of Maryland Sch of Med, Baltimore.
- Mar 14-16 **Clinical Pharmacology—Rational Basis of Therapeutics**, Univ of Calif Sch of Med, San Francisco.
- Mar 19-23 **Internal Medicine: What's New?** Univ of Alabama Med Cen, Birmingham.
- Mar 22-24 **Clin Recognition & Mgt of Heart Disease 1973**, Arizona Med Cen Hosp, Tucson Ariz.
- Mar 26-30 **Cardiology 1973**, Topics of Current Interest. Mt Sinai Sch of Med, New York City, Americana Hotel.
- Apr 4-6 **Recent Advances in Diagnosis & Mgt of Pulmonary Disease**, Va Mason Med Cen, Seattle.
- Apr 24-27 **Pulmonary Disease**, Univ of Pa Sch of Med, Philadelphia.
- Apr 25-27 **Hepatobiliary Disease in Clinical Practice**, Hilton Hotel, San Francisco. Sponsors: Presbyterian Hosp of Pacific Med Cen & Dept of Gastroenterology, Univ of Calif, San Francisco.
- Apr 25-27 **Advances in Diagnosis & Mgt of Infectious Disease**, Univ of Wisconsin, Madison.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

(For info on these mtgs, contact ASA, 515 Busse Highway, Park Ridge Ill 60068.)

- Mar 11-15 **47th Congress—International Anesthesia Research Society**, Americana Hotel, Bal Harbour Fla.
- Mar 17-18 **Pediatric Anesthesia**, Univ of Tennessee Col of Med, Memphis.
- Mar 24 **14th Anl Postgrad Anesthesia Seminar—NJ State Society of Anesthesiologists**, Cherry Hill Inn NJ.

- Mar 24-25 **ASA Workshop on Fluid & Transfusion Therapy**, Fairmont Hotel, Dallas.
- Apr 2-4 **Anl Postgrad Crs in Anesthesiology**, Emory Univ, Atlanta.
- Apr 2-6 **Clinical Anesthesiology for the General Practitioner**, Oklahoma City.
- Apr 13-15 **10th Anl Spring Scientific Mtg, Va Society of Anesthesiologists**, Richmond.
- Apr 23-25 **23rd Anl Postgrad Symposium on Anesthesiology**, Univ of Kansas Med Cen, Kansas City.
- Apr 27 **Muscle Relaxants & Ventilation**, Ohio State Univ, Columbus.
- Apr 28-29 **Obstetrics Anesthesia**, Univ of Tennessee Col of Med, Memphis.
- Apr 28-29 **ASA Regional Refresher Crs**, Grove Park Inn, Asheville, NC.

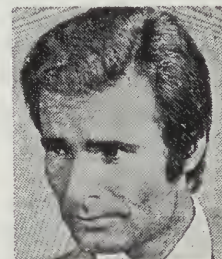
MISCELLANEOUS MEETINGS

- Mar 12-16 **166th Anl Postgrad Crs in Diagnostic Radiology**, San Francisco, \$150 fee. Contact: Dept of Cont Educ in Hlth Scences, 570-U, Univ of Calif, San Francisco Calif 94122.
- Mar 15-16 **22nd Anl Postgrad Crs in Pediatrics**, Galveston Tex. 12 hrs AAGP. \$75 regls fee. Contact: Lillian H Lockhart MD, Dept of Pediatrics, Univ of Texas Med Branch, Galveston Tex 77550.
- Mar 19-22 **Controversial Issues in Pediatric Cardiology Symposium**, Miami. Contact: Div of Cont Educ, Univ of Miami Sch of Med, PO Box 875, Biscayne Annex, Miami Fla 33152.
- Mar 21-24 **Postgrad Emer Med Seminar**, Playboy Plaza Hotel, Miami Beach. Sponsors: Univ Miami Sch of Med & Florida Chapter ACEP. Contact: Dr J C Findeiss, Florida Chapter, ACEP, 11130 SW 173rd Terrace, Miami, Fla 33157.
- Mar 22-24 **Clinical Chemistry Measurements Symposium**, Washington Hilton Hotel. Sponsors: Assoc for Adv of Med Instrumentation & Natl Bureau Stds. Contact: AAMI, 1500 Wilson Blvd, Suite 417, Arlington Va 22209.
- Mar 22-25 **1973 Natl Medicolegal Symposium**, Las Vegas Hilton, Las Vegas. Sponsors: AMA & Amer Bar Assoc. Contact: American Bar Assoc, 1155 E 60th St, Chicago Ill 60637.
- Mar 26-29 **Crs in Neurology**, Chicago. Sponsor: Abraham Lincoln Sch of Med & Univ of Illinois Hosp Eye & Ear Infirmary. Limited to 12. Contact: Dept of Otolaryngology, 1855 W Taylor St, Chicago Ill 60612.
- Mar 26-31 **Selected Topics in Genitourinary Roentgenology**, Playboy Plaza Hotel, Miami Beach. Contact: Manuel Viamonte MD, Det of Radiology, Univ of Miami Sch of Med, Box 875, Biscayne Annex, Miami Fla 33152.
- Mar 29-30 **26th Natl Conf on Rural Health**, Statler-Hilton Hotel, Dallas. Contact: Dept of Rural Health, Div of Med Practice, 535 N Dearborn St, Chicago Ill 60610.
- Apr 1-4 **1st Anl Spring Mtg, American Col of Surgeons**, Americana & Hilton Hotels, New York City. 8 postgrad crs. Contact: ACS, 55 E Erie St, Chicago Ill 60611.
- Apr 4-6 **Critical Care Program for Nurses & Physicians**. Nashville. Sponsors: Amer Col of Chest Physicians & Vanderbilt Univ Sch of Med. Contact: ACCP, 112 E Chestnut St, Chicago Ill 60611.
- Apr 16-19 **1973 Amer Industrial Hlth Conf**, Denver Hilton Hotel, Denver. Sponsors: Ind Med Assoc & Amer Assoc of Ind Nurses. Contact: American Industrial Health Conference, 150 N Wacker Dr, Chicago Ill 60606.

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Commissioner

Baltimore City health department

Smith Coordinates Lead Poisoning Project

Mr William R Smith has been appointed Administrative Health Officer and Project Coordinator for the City's new federally-funded child lead poisoning detection and prevention program.

Mr Smith, formerly Area Superintendent in the City Department of Housing and Community Development, has been employed in housing code enforcement work in Baltimore City for more than 20 years. His first assignment in this field was in 1952 as a Housing Enforcement Officer in the City's Housing Bureau, previously a unit of the Health Department.

A graduate of Morgan State College and a veteran of both World War II and the Korean conflict, Mr Smith has been close to Baltimore's housing problems, including lead paint poisoning, as a result of his inspection work and as a supervisor who coordinated enforcement activities with other city agencies including the City Health Department. Mr Smith has also completed studies in City Planning under the auspices of the American Institute of City Planning.

In his new post Mr Smith will play a major role in administering and developing the policies and procedures of Baltimore City's expanded lead paint poisoning detection program.

Lead Detection, Prevention Program

The new child lead poisoning project, funded for its first year of operation by the US Bureau of Community Environmental Management in the amount of \$150,000, with \$76,600 in City matching funds, will, when in full operation, screen for lead all children in the critical age groups from one to six years old at 16 City Health Department and community health centers, see that hazardous lead paint is removed, and con-

tinue the Department's education of the public about this danger. Existing resources will be expanded and a total of 12 new staff members will be employed to assist in this work. Children found to have lead poisoning will be referred for treatment.

Baltimore's lead poisoning control efforts go back 40 years. Since 1931 Health Department records show 1,181 children poisoned of whom 137 have died. Many others are believed to be unknown victims who have suffered some mental or physical impairment.

Currently, the City Health Department is continuing its work in the investigation of children reported to have lead poisoning or elevated blood leads. This involves locating the source of illness and removal of the lead paint. In addition, close cooperation is maintained with the John F Kennedy Institute's lead screening project in East Baltimore to correct lead paint hazards in homes of children found with lead poisoning or high blood lead levels.

Director of the new lead detection project is Mr George W Schucker, Assistant Commissioner of Health for the City Health Department's Sanitary Services. Assistant Director is Mr Elkins W Dahle Jr, Director of the Bureau of Industrial Hygiene. Mr Smith's office is on the sixth floor of the American Building, telephone 752-2000, extension 509.

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MRS ROBERT A REITER
Editor

woman's auxiliary

DRUG ABUSE: COMMUNITY PERIL

There are some puzzles mankind seems unable to solve. For example, it would appear easier for man to walk on the moon than to curb drug addiction. Many earnest attempts at rehabilitating a devoted addict have met with little success; and now, with the appalling figures of child addiction in the schools, the main theme is on education.

Your Medical Auxiliary is prepared to help in this endeavor. The Auxiliary's National Health Education Committee is ready to serve as a resource to advise County Auxiliary Chairmen of available materials which are suitable for their particular programs. These include books, pamphlets, brochures, prepared speeches, films, television and radio materials, all free of charge. It is then up to the county chairmen to ascertain the particular community needs and let health authorities, departments of education, PTA groups, etc know the material is available.

The Auxiliary film, "Drugs Are Like That," geared for the fifth and sixth grades, has been shown in the schools of two of our counties with the approval of the Departments of Education. One county's educators were so well pleased that they are purchasing the film for future showing.

Television commercials have made the taking of pills practically a natural reflex. Constantly reminded of how much better one feels from swallowing a pill, the teenagers go with the greatest of ease to swallowing amphetamines and barbiturates. Auxiliarians could start a letter-writing campaign to the national networks to reduce the amount of commercials promoting patent medicines. Senator Birch Bayh, of course, is blaming the drug abuse on legitimate pharmaceutical companies who, he says, are over-producing addictive capsules in order to permit their flow into black market channels.

The Auxiliary can help drug rehabilitation

through its legislative committee by pressuring legislators, Veteran's Administration officials, educators, research institutes, and Foundations to get on with finding methods of cure, methods of effective education, determining if marijuana need be classified with dangerous and addictive drugs, and analyzing why American servicemen in Vietnam were so vulnerable to heroin.

Today's drug abuse "authorities" when quoted in the press continue saying, "We need more study, more analysis."

How much study do they need? The fantastic spread of drug addiction right under their noses for the past ten years must have been obvious. Then a little look into past history shouldn't be too difficult. When the East India Company, with its gunboats, forced opium down the throats of the Chinese, their once great civilization ended. There is the terrifying figure of the "Old Man of the Mountain" who fed his men hashish and then sent them out to murder the leaders of the Crusades. The very word "assassin" comes from the Arabic word for hashish.

Today's underground press which extols the delights of the drug culture cannot be suppressed because of our tradition of a free press, but literature has influenced people through the ages. For example, the talented brother of the famous Bronte sisters became an opium addict after reading De Quincey's "Confessions of an English Opium Eater," thus ending a promising career. Education and self-discipline would seem to be the answer here.

It is said our crash moonflight project was triggered by the Russian "sputnik." Previously, our scientists had been working leisurely on the involved problems, but the competition sent them into high gear.

What will send our authorities on drug abuse into high gear?

American Association of Medical Assistants

AAMA - Maryland

The following members have been named to serve for the 1973 AAMA Convention:

Mrs Dorothy Hartel, Vice Chairman

Mrs Jean Jacobson, Decorations Committee Chairman

Mrs Nell Chaney, Publicity Vice Chairman and Convention Newsletter

Mrs Eleanor Stuck, Maryland Welcoming Party Chairman

Mrs Mabel Young, Maryland State President

The biggest news affecting members at the 16th Annual AAMA Convention in Phoenix (Oct 17-18) was the \$5 increase in annual dues.

The Certifying Board reported that the mini-test will be offered to local chapters on a first-come basis; micro-mini-test "do it yourself" instructions will be issued local chapters; a progress report was made on the Pediatric Medical Assistant program.

Dr C A Hoffman, AMA President, in speaking to the 1,000 convention attendees, said, "We of the AMA make much of the doctor-patient relationship because we earnestly believe in it, and because the patient expects and needs it; but there also has to be a medical assistant-patient relationship." He said that medical assistants contribute "not only technical efficiency but a warm understanding of patients."

Baltimore Chapter

At the Nov 14 meeting, the Baltimore Chapter elected the following officers:

President, Leila Adams

President-elect, Jean Jacobson

Vice President, Carol Rohrer

Recording Secretary, Vicky Flanigan

Corresponding Secretary, Janet Kudurna

Treasurer, Eleanor Stuck

State Representative, Rita Cobry

Advisor, Ronald N Kornblum MD

Mrs Catherine Taylor served as Chairman of the Dec 12 Christmas Party at Overlea Hall. Entertainment by Dr Hyman Rubinstein on the violin, accompanied by Mrs Rubinstein on the piano, was pure delight.

The new officers were installed in a candlelight service conducted by Mrs Dorothy Hartel. Climax of the evening was an exchange of gifts with Mrs Catherine Taylor playing the piano for a sing-a-long.

1973 Convention

The 1973 AAMA annual convention will be held at the Shoreham Hotel in Washington, DC the week of October 22nd. This convention will be hosted by the AAMA—District of Columbia, AAMA—State of Maryland, and the AAMA—State of Virginia. This will be a first since, in the past, only one state has hosted a convention.

A convention meeting was held at the Shoreham Hotel in Washington on Nov 11, 1972. There will be several outstanding physicians on the program from Maryland; names will be announced after confirmation.

There will be preconvention tours of Washington, Annapolis, and Williamsburg. Details will be ironed out later.

There will be a post-con-

vention tour to Puerto Rico, five nights and six days; and a two-week tour of Eastern Europe, Warsaw, Moscow, etc.

The theme of the convention will be "MONUMENTAL GOALS." The Mayor of the District of Columbia and the governors of Maryland and Virginia will be invited to give a welcome at the opening of the general session. The presidents of all three medical societies will be invited to address the general session also. One evening will be set aside to see whatever event is taking place at the Kennedy Center.

There will be a State Party on Monday evening, Oct 22; Mrs Eleanor Stuck of Maryland is Chairman. Another meeting will be held on Jan 22, and a further report will be released to the membership.

•

Safety Enclosures For Rx Containers

In comments addressed to the Food and Drug Administration, the Pharmaceutical Manufacturers Association has supported a proposed requirement that childproof safety packaging be introduced for oral prescription medications.

The endorsement noted that there may be a need for exemptions for specific medications that present no hazard, or which must be handled by infirm patients, or for which no practical safety closure is available.

A major supply problem is in prospect as closure manufacturers gear up for the demand. PMA therefore requested a year's delay to allow closure manufacturers and drug firms to make necessary arrangements without disrupting the nation's prescription drug supply.

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MEET YOUR NEW COUNCIL MEMBERS

The series on new Council members continues with the spotlight this month on Frederick E Musser MD, 5938 Westchester Park Drive, College Park, Md.

Dr Musser assumed the office of Councilor for the South Central District of the Faculty at the conclusion of the Annual Meeting on May 5, 1972.

He has been living in the Landover Hills area where he has had a General Family Practice since 1946. He was born and raised in Central Pennsylvania, attending Juniata College, Huntingdon, Pa, where he received his BS degree.

Dr Musser received his MD at the University of Buffalo and completed his internship at Sibley Hospital, Washington, DC. After a tour of duty with the Air Force at Bolling Field, he established a Family Practice in Landover Hills.

In addition to service as President of the Prince George's County Medical Society for the year 1965, Dr Musser was on the executive board for eight years, has served in other offices and on many committees, and is currently a Council member of the Medical and Chirurgical Faculty of the State of Maryland. In 1965 he was nominated as Maryland's "Doctor of the Year."

Dr Musser has engaged in many important Prince George's County community activities, including civic efforts, youth programs, and service club activities. He has for years been an active member of the local Kiwanis Club. He has served the youth of his County as a 4-H Club leader and also as a member of the County Physical Fitness Com-



Dr Musser

mittee. In 1967 he was appointed by the County Commissioners to the Health Planning Advisory Committee for Prince George's County.

With respect to area health problems, Dr Musser has been a member of the Steering Committee of the Health Study Council and also an active worker for the same organization on its Anti-Poverty Committee.

His work as a member of the Prince George's County Community Action Committee is well known to the community at large, and he has served the society and other physicians in the entire Metropolitan Area by serving three terms on the Medical Council of the DC Metropolitan Area.

Dr Musser's contributions to his community are manifold and have extended over a long period of time to such an extent that it is difficult to believe he can still find time to maintain a very active general practice, as well as to relax a bit as a weekend farmer at his country place in Frederick County.

PUBLIC AFFAIRS WORKSHOP PLANNED

The annual AMA-AMPAC PUBLIC AFFAIRS WORKSHOP will be held this year on Saturday and Sunday, March 10 and 11, at the Washington Hilton Hotel, Washington, DC. As in the past, the Workshop is sponsored by the American Medical Association and the American Medical Political Action Committee.

The program will include workshops in which everyone is invited to participate, as well as nationally known speakers. While the names of the speakers have not yet been announced, be assured that they will be provocative and interesting.

There will also be the usual social events where you will have the opportunity to meet and chat with physicians and their wives from all over the country who share your interest in the future of medicine from the political standpoint.

Further details will be available from the Faculty office as received from AMA-AMPAC. Put these dates on your calendar and plan to attend. You won't be sorry!

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DANIEL V LINDENSTRUTH MD
Editor

A Service of the Heart Association of Maryland

the heart page

Ultrasound Measurement of Left Ventricular Function in Acute Myocardial Infarction

(Preliminary Report)

DAVID SCHNEIDERMAN

Mr Schneiderman is a student at Woodlawn Senior High School, Baltimore. He was one of 20 recipients of a Summer Scholarship provided by the Central Maryland Heart Association. His preceptor was Donald H Dembo MD at Maryland General Hospital, Baltimore.

Introduction

Ultrasound has been of increasing value as a noninvasive diagnostic technique. It is of proven value in the quantitative assessment of pericardial effusion, intracardiac masses and valvular disease, such as mitral stenosis. More recently, Feigenbaum has measured stroke volume with acceptable reproducibility. Pombo compared cardiac output as determined by ultrasound and dye dilution methods with favorable results. Troy has suggested that the thickness of the left ventricular wall as estimated with ultrasound, correlates well with ejection fraction as a measure of myocardial contractility.

It was thought that the determination of stroke volume, cardiac output, and left ventricular contractility might be useful in assessing serially the pathologic physiology of acute myocardial infarction. Scholarship goals were to establish the standard technique for determining cardiac output and to establish its reproducibility in normal controls.

Method

The ultrasound examinations were performed by the method of Pombo with a commercially available echo machine (Unirad Corp) utilizing a 2.25 megahertz transducer, 0.75 inches in diam-

eter, with a repetition rate of 1000 impulses/second. The patients were examined while in the recumbent position and the transducer adjusted to obtain a clear recording of the interventricular septum, mitral valve, and anterior and posterior myocardium. The "slow sweep" of "time motion" presentation was used to record the echoes; in this technique, distance is plotted against time. A simultaneous electrocardiogram was superimposed identifying the appearance time of echoes in the cardiac cycle. The simultaneous heart rate was used to convert stroke volume to cardiac output.

A typical echogram from which cardiac output and stroke volume can be determined is shown in Fig 1. The distance between the endocardial echo of the left side of the septum and the endocardial echo of the posterior left ventricular wall, can be measured at end-diastole and end-systole.

Data

The left ventricular internal dimension during both end-systole and end-diastole are each cubed separately and their difference is found to determine stroke volume. Cardiac output was calculated by multiplying the stroke volume by heart rate.

A compiled record of five serial ultrasonic testings over a period of five days is shown in Table 1. The subjects, aged between 17 and 30 years, had no cardiac abnormalities. For each subject, the stroke volume in cubic centimeters and the pulse, in beats per minute, have been recorded. The stability of the stroke volume over a period for each subject is apparent.

Discussion

It is evident that the data are reproducible. The transducer was often too large to fit between the intercostal spaces particularly in asthenic subjects. A pediatric transducer, between one fourth and one half inch in diameter is useful for those subjects with smaller rib cages.

Obesity increases the distance between the transducer and the heart; in some instances, suitable echograms could not be recorded. Because the beam is so powerful and direct in its course, the angle formed by the transducer and the chest is crucial. The slightest movement of the transducer can create an entirely different image on the oscilloscope. It is vital to collect clear, precise recordings of the echoes, and careful measurements must be made. Because the

diameter is cubed, one mm can affect the volume calculated.

The formula for stroke volume assumes that the heart is a symmetrical ellipsoid. It is not yet known if this principle can be applied to the abnormal heart, specifically with myocardial infarction. However, since serial recordings are anticipated, it is hoped that each patient may serve as his own control.

Conclusion

The reproducible data demonstrates the usefulness of ultrasound as a noninvasive method of measuring cardiac output. The further detection of myocardial contractility and its application to patients with acute myocardial infarction may provide objectivity and predictability in its management.

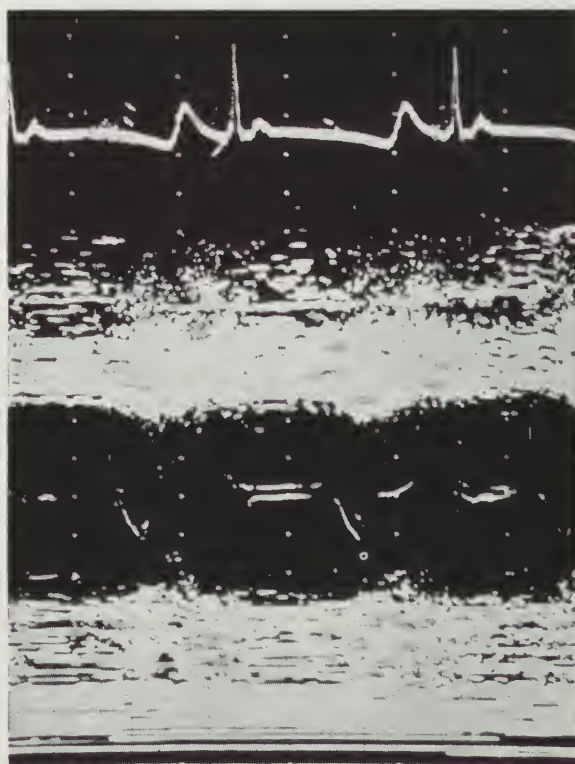
Table 1: Ultrasound Cardiac Output

Subject	Day 1 Stroke Vol	Pulse	Day 2 Stroke Vol	Pulse	Day 3 Stroke Vol	Pulse	Day 4 Stroke Vol	Pulse	Day 5 Stroke Vol	Pulse	Mean Cardiac Output
17 WM	85	48	85	48	85	56	85	56	85	56	4.68 Liters Min.
23 WM	77	60	75	60	77	56	77	60	77	64	4.62 Liters Min.
17 WF			74	78	74	82	74	80	74	78	4.70 Liters Min.
17 WF	78	72	78	72	78	64	78	64	78	64	5.06 Liters Min.
30 WM	80	70	80	72	80	72	77	72	80	72	5.68 Liters Min.

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1. Feigenbaum H, et al: Left ventricular stroke volume measured by ultrasound. *Circulation* XL:iii-79, Oct 1969.
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3. Troy BL, et al: Ultrasonic measurements of left ventricular wall thickness and mass. *Circulation* XLII:iii-38, Oct 1970.
4. Stone JM, et al: Use of ultrasound to detect volume overload of the left ventricle. *Circulation* XL:iii-196, Oct 1969.
5. Pombo J, et al: Measurements of left ventricular volume and ejection fraction by echocardiography. *Circulation* XLII:iii-64, Oct 1970.
6. Fortuin NJ, et al: Evaluation of left ventricular function by echocardiography. *Circulation* XLII:iii-120, Oct 1970.

Fig 1: Typical echocardiogram. PW-posterior left ventricular wall; MV-mitral valve; S-Septum.



PEDIATRIC EMERGENCIES

Third Annual Symposium sponsored by
Committee on Emergency Medical Services of the
MEDICAL AND CHIRURGICAL FACULTY

THURSDAY, MARCH 29, 1973

at the

PRINCE GEORGE'S GENERAL HOSPITAL
Cheverly, Maryland

9:15 am—Introductory remarks

12:30 pm—LUNCH

9:30 am to 12 noon—Multiple Trauma
Bleeding Disorders
Management of Burns

2:00 pm to 4:30 pm—Convulsive Disorders
Status Asthmaticus
Medical Legal Responsibilities

Names of the speakers will appear in the March issue of the Journal. A complete program will be mailed to all Faculty members and to others upon request.

This continuing medical education program of the Medical and Chirurgical Faculty is acceptable for five and one half credit hours for the Physician's Recognition Award of the American Medical Association and by the Maryland State Board of Medical Examiners for license reregistration of physicians.

HALUK B BONEVAL MD, Chairman
Ad Hoc Planning Committee for Symposium

DETACH AND MAIL THE FOLLOWING REGISTRATION FORM TODAY TO:

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Medical and Chirurgical Faculty
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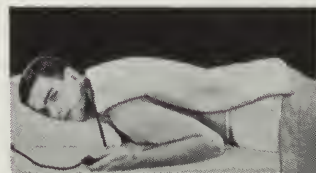
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executive director's newsletter

February 1973

PHYSICIAN ALERT

Physicians are being alerted to another get rich-quick scheme offered through a North Hollywood, California outfit. Physicians are being billed for large sums, allegedly for laboratory services to be used in the future by the physician. Along with the bill comes a set of stickers that are good for various tests. The physician is supposed to send the blood or other sample with the sticker and the results will be mailed back to the physician, who pays in advance for the stickers.

We suggest physicians look carefully at bills that come into their office and know specifically what they cover and if they are legitimate.

PHYSICIAN PROFILES

Physicians may request from Maryland Blue Shield, Inc a copy of their profile used in computing payment based on their UCR fees. A written request for same is required. Such should be sent to Blue Shield at its office address.

FEE INCREASES

Physicians who haven't increased their fees since Jan 1, 1971 may be eligible to raise them by a cumulative 5%, effective Jan 1. Physicians are permitted to increase fees 2.5% annually without seeking prior approval by the IRS, but must be prepared to justify the increase. Physicians should note that only higher costs incurred since Jan 1, 1971, or since they last raised fees, whichever is later, may be passed on in the form of higher fees. Price Commission guidelines do not permit MDs to pass on increased costs that occurred prior to Jan 1, 1971.

Physicians are cautioned that they will not be permitted to increase their fees if the additional income resulting from such an increase would raise their profit margin above the base period. Base period profit margin is defined at the ratio of net profit, before taxes, to total revenue. Those physicians who feel that they have suffered a gross inequity or serious hardship may apply for an exception to the regulations. They should use forms S-16 and S-53 for this purpose. The forms may be obtained from the IRS district director.

DUES
BILLS
PAID

All members are reminded that dues for 1973 must be paid by Jan 31, 1973 in order to be eligible for legal defense (provision of a physician's panel to evaluate defensibility of a malpractice action). Dues bills and reminders have already been mailed. If you have not received your copy, please let the Faculty office know.

RESOLUTIONS
FOR
ANNUAL
MEETING

Resolutions for consideration by the House of Delegates at the Annual Meeting in April, must be received in the Faculty office prior to Friday, Mar 2, 1973. Article XI, Section 26, establishes this deadline for resolutions unless introduced by the Council or committees of the Faculty.

MD LICENSE
PLATES

Only physicians will be eligible for use of car license plates when they are reissued in 1975 that have the letters MD preceding the ordinary numerical sequence.

Arrangements have been completed with the Department of Motor Vehicles to restrict issuance of such plates to physicians. All such applications will be processed through the Faculty office. More details closer to that date in 1975.

AMA COMMITTEE
ON
LONG-RANGE
PLANNING

The regional meeting of the AMA Committee on Long-Range Planning is set for Friday, Mar 9, 1973 at the Washington Hilton Hotel preceding the Public Affairs Workshop. Members may appear to present testimony in person or may submit written data in this regard.

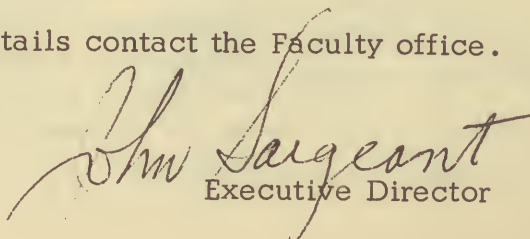
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A limited number of seats have been made available to members of the Faculty on affinity charters departing from New York City as follows:

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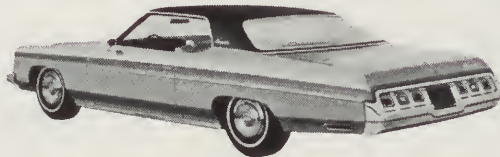
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Mercy Hospital is an acute general, metropolitan and central city hospital of 364 beds and 46 bassinets. Located in the heart of downtown Baltimore, it has been under the direction of the Sisters of Mercy since 1874.

Its main patient care areas, laboratories, and supporting services are housed in the 20-story Tower Building completed in 1968. It is fully accredited by the Joint Commission on Accreditation of Hospitals.

An educationally oriented institution since its inception, today it is a major teaching affiliate of the University of Maryland School of Medicine. Students in their II, III, IV years receive clinical training in Medicine, Pediatrics, Obstetrics and Gynecology Surgery, Cardiology, and Gastroenterology.

A system of rotating residencies has been established with University Hospital in addition to Mercy's own 12-month programs for interns and Medical and Pediatric residents.

The Mercy School of Nursing was established in 1898 and has graduated over 2,300 registered nurses to serve the Baltimore community, the armed forces, and special missions throughout the world.

The hospital also conducts a School of Radiologic Technology and, in conjunction with Mt St Agnes and Loyola Colleges, a baccalaureate program in Medical Technology.

The care of patients is organized into four major clinical departments: Medicine, Obstetrics and Gynecology, Pediatrics, and Surgery; each

has its own fulltime department head, jointly appointed by the Hospital and the University of Maryland School of Medicine.

Other departments and special services maintained for the care of patients are laboratories (both Clinical and Research), Anaesthesiology, Cardiology, Minor Surgery, Gastroenterology, Ophthalmology, Physical Medicine, Radiology, Otolargngology, and Nuclear Medicine.

The Mercy Ambulatory Patient Department has been approved by the federal government to demonstrate to the nation's hospitals the feasibility of making outpatient departments a more effective factor in the delivery of primary medical care of optimum quality to innercity populations, both resident and commuting.

The orientation and organization of the department is not based on the concept of financial need; rather, it is based on the need for complete, effective, and accessible medical services where there exists the highest concentra-

tion of people as the result of urban redevelopment. It is characterized by the continuity and individuality of the patient-doctor relationship usually associated with private practice and by the availability at the site of treatment of a full complement of medical specialists for patient referrals.

Sister Mary Thomas RSM is President; Daniel J Pessagno MD is Chief of Staff.

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HOSPITAL AWARD—Lewis P Gundry MD received the St Agnes Hospital (Baltimore) Department of Medicine's award for outstanding contributions to patient care and medical education. The presentation was made by John H Shaw MD, St Agnes' chief of General Practice. Pictured L to R: George H Yeager MD, director, University of Maryland Hospital; Luis G Martin MD, last year's winner; Emile R Mohler Jr MD, chairman, Department of Medicine, St Agnes; Dr Gundry; Dr Shaw; and Emidio A Bianco MD, director of medical administration and education at St Agnes.

Doctors in the News

Claro L La Vina MD, Cockeysville, has been certified as a Diplomate of the American Board of Anesthesiology.

At the annual meeting of the Maryland Society of Internal Medicine at the Engineers Club in Baltimore, the following officers were elected to a two-year term:

Thomas E Van Metre MD, President

Wilmer K Gallagher Jr MD, Vice President

Sheldon Goldgeier MD, Secretary-Treasurer

Arnold M Seligman MD, Chief of Sinai Hospital of Baltimore's Department of Research Oncology and Cell Biology, has been named a lifetime Research Professor by the American Cancer Society.

The award gives Dr Seligman the distinction of being one of only 23 American doctors so honored, the first in Maryland, and the only surgeon ever to receive it.

The grant enables Dr Seligman to continue his research in developing new cancer chemotherapeutic agents and new methods for the study of components of cancer cells with the light and electron microscope.

A cancer researcher of international repute, Dr Seligman was named Maryland Chemist of the Year last September (see December *Journal*).

Victor A McKusick MD, chief of the medical genetics division at Johns Hopkins University School of Medicine, was the cover story subject of the November 13 issue of *Modern Medicine*.



Dr Kime

Watson Kime MD, director, Department of Laboratory Medicine, South Baltimore General Hospital, has been elected Chairman of that institution's Medical Staff. He succeeds **Chris Papadopoulos MD**.

Also newly elected as officers of the Medical Staff were **Neil Novin MD**, Vice President; and **Larry Awalt MD**, Secretary-Treasurer.

Henry N Wagner Jr MD, professor of medicine, radiology, and radiological science at the Johns Hopkins Medical Institutions, has been awarded the first **Vikram Surhabai Gold Medal** by the Society of Nuclear Medicine of India.

The award was made in Madras, India, where Dr Wagner delivered the **Vikram Surhabai** oration.

His selection was made on the basis of his numerous contributions to the field of nuclear medicine in the last decade.

Governor Mandel has ap-

pointed 11 new members to the Maryland Advisory Council on Comprehensive Health Planning Agency.

The only doctor included was **Torrey C Brown MD**, a member of the House of Delegates (D-2, Baltimore) and an assistant professor of medicine at Johns Hopkins University.

Newly appointed ex officio members who are chairmen of area-wide advisory councils include **William S Spicer Jr MD**, Baltimore Region, associate dean, University of Maryland School of Medicine.

Reappointments included **Robert W Gibson MD**, medical director, Sheppard and Enoch Pratt Hospital.

Established in 1968, the 43-member council advises the agency on the development of a coordinated statewide system of comprehensive health planning for mental and physical health. The majority of its members must be consumers rather than providers of health care.

Hans Wilhelmsen MD, Towson, has recently been approved as a member of two national plastic surgery societies: the American Society of Maxillofacial Surgeons, and the American Society for Aesthetic Plastic Surgery.

Elihu E Allinson MD, chief of psychiatry at Baltimore's North Charles General Hospital, has been elected Mid-Atlantic Representative (Area III) to the Assembly of District Branches of the American Psychiatric Association.

Dr Allinson will fill this position concomitantly with his present office as Delegate to the Assembly of District Branches from Maryland, in which position he has served since 1967.

Medical Miscellany

Peer Review

The AMA is assisting 23 medical specialty associations in efforts to develop guidelines for use in local peer review activities. Participating in the program are representatives from those specialty associations that comprise AMA's Interspecialty Council. The guidelines will be developed independently by the individual specialties with the AMA serving in a coordinating role.

Legislative Activities

The AMA is expanding its program of legislative activities to meet changing needs and priorities. It created a position in the Washington Office for a legislative attorney who will devote attention to the interests of national medical specialty societies.

It also appointed an ad hoc committee on federal-state legislation to guide the AMA toward better correlation of legislative proposals, particularly those of broad significance that are emerging in state legislatures. The committee comprises seven state and county medical society executives.

Pharmacology-Morphology Awards Given

The Pharmaceutical Manufacturers Association Foundation has announced the award of five fellowships worth \$118,000 to researchers studying the actions of drugs through morphologic approaches, in an interdisciplinary training program.

The awards bring the PMAF program in pharmacology-morphology to the \$450,000 level, with 21 awards made since the project was undertaken in 1968.

The PMA Foundation was established in 1965 to advance the science of therapeutics. Supported almost entirely by donations from prescription drug firms, the Foundation has provided more than \$3.4 million for research and training.

Medicare Risks

Physicians run the risk of being subjected to retroactive denial of Medicare benefits unless they are able to provide acceptable documentary evidence substantiating dates of their hospital visits, the AMA warns.

As a precautionary measure, the AMA urges physicians to "make sure that there is an entry on the hospital record for each patient substantiating the date of each visit."

To guide physicians the AMA has developed an informational statement based on Medicare rules and verified by the Bureau of Health Insurance. Write the Division of Medical Practice, AMA.

NIH Studies

Tumor Antigens

The cooperation of physicians is requested in the referral of patients for studies of tumor antigens being conducted by the National Cancer Institute's Immunology Branch at the Clinical Center, National Institutes of Health, Bethesda, Md.

Needed are patients who have: 1) a confirmed diagnosis of chronic lymphocytic leukemia; 2) both biologic parents living; 3) a WBC count of 15,000/mm³ or greater, if treated — although previously untreated patients are of particular interest.

Physicians interested in having their patients considered for admission to these studies may write or telephone Howard B Dickler MD, Clinical Center, Room 4B18, National Institutes of Health, Bethesda, Md 20014, phone 301-496-1376.

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Sickle Cell Anemia Attacks

"Crisis" attacks in sickle cell anemia may be triggered or enhanced by one type of prostaglandins, fatty acids manufactured in many body tissues. In sickle cell anemia—a heredity blood disease found primarily in blacks—red blood cells become elongated and crescent-shaped, like sickles.

Unlike normal red cells, they have difficulty passing through the smaller blood vessels. As a result, blood flow is impeded and the oxygen sup-

ply to various tissues is reduced, causing pain and, often, malfunction of organs and disability.

Stanford University investigators found that Prostaglandin E2 induced increased sickling in the red cells of sickle cell patients. Their experiment followed the observation that certain symptoms of sickle cell crises, such as inflammation and fever, simulated symptoms which can be induced by prostaglandin injections. The next step, said Dr Paul L Wolf, is to try and find drugs that can inhibit prostaglandin action.

Opinion Survey

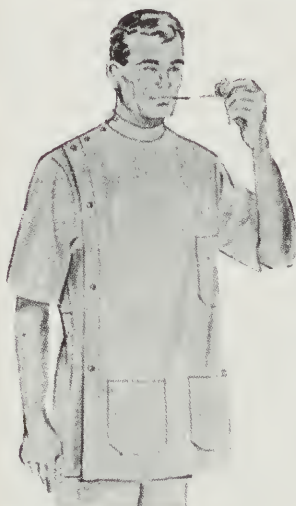
The 1972 AMA Opinion Survey revealed that AMA members and nonmembers pretty well agree on major issues. Both members (73.2%) and nonmembers (66.9%) want AMA to continue to seek to retain basic principles of private practice in any government health program that might be enacted.

Comparable proportions of members (24.6%) and nonmembers (27.5%) said they would practice under a nationalized health program if it were enacted.

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John Galsworthy

FREDERICK J BALSAM MD
Editor

rehabilitation medicine

THE ROLE OF SPORTS IN REHABILITATION OF THE HANDICAPPED

Part 1A: Historical

NORMAN B ROSEN MD

Dr Rosen is Assistant Physician-in-Chief and Director of Rehabilitation Therapies for the Maryland Rehabilitation Center, 2301 Argonne Dr, Baltimore, Md 21218. He is also Consultant in Rehabilitation Medicine at Baltimore's North Charles General Hospital and Kernan Hospital for Crippled Children.

Information and reprint requests to Dr Rosen.

Of all the tragedies to befall a healthy man or woman, certainly one of the most feared and bewildering is to be rendered physically disabled as a result of some catastrophic event. Among the innumerable physical disabilities, certainly none is more threatening to the self-confidence, morale, and self-respect than to become paraplegic or worse, quadriplegic as a result of injury or disease to the spinal cord.

Even in the minds of many physicians, supremely sophisticated in other aspects of medical care, paraplegia is intrinsically associated with an "end of the line" concept. Immediately envisioned are pictures of healthy minds trapped in immobile bodies, subject to myriad medical and social complications, no longer able to perform at the will of the unfortunate victim. In fact, as a result, frequently the response elicited in the very professionals who should be charged with positive action, definite goal planning, and therapeutic objectivity is one of neglect or, at best, tacit acceptance of the "inevitability" of the patient's fate.

Fortunately, with increasing sophistication on the part of both the medical and lay communities, an improved level of understanding, as well as an actual improved outlook for functional return of the handicapped to society, has developed in the wake of increased longevity and de-

creased morbidity. "Rehabilitation" has indeed become a household word, and restoration and adjustment have supplanted survival and acceptance in the day-to-day priorities and needs of the handicapped. Attention can currently be directed not to *if* or *how* an individual can be rehabilitated but to *when* he can return to a functional independent existence. However, one must not minimize the actual physical, medical, and emotional problems that the handicapped and, in particular, the para- or quadriplegic patient must still overcome in order to accept his disability and succeed in his endeavors.

The paraplegic-quadruplegic and otherwise handicapped patient still faces a variety of problems and complications that are unique to his particular type of pathology. The paraplegic, for example, must live with the ever-present threat of an increased susceptibility to lung and kidney infections and to the likelihood of developing skin ulcers if he fails to pay strict attention to his skin care. He must be ever concerned with the problem of adapting his wheelchair existence to the environmental restrictions of a world that is still not aware that he would be able to function more adequately and independently with only a minimum of obvious and, often, quite simple changes in the physical environment. He must live with the realization

that it is essential that he maintain his body at a specific level of conditioning so that he can continue to function in society despite his other physical limitations. He must further be aware of the deleterious effects of deconditioning, not only from the standpoint of the negative effects that deconditioning would have on his physical being, but also those adverse effects relative to his emotional being as well.

It is in this regard that participation in sports has such favorable ramifications for the handicapped and the disabled.

History of Physical Activity in Medicine

Physical activity has long been considered valuable in the treatment of a variety of ailments and essential in the maintenance of good health. It promotes physical, as well as emotional, well-being. Sport, as a form of physical activity, provides an opportunity for both individual expression and social interaction. It is for these reasons that sport has had such wide appeal.

For the healthy and able-bodied, gymnastics developed as a result of this need for physical and emotional expression.

It was only logical to extend this principle to the treatment of the ill and the disabled. Since the time of Hippocrates, there have been advocates of the use of physical activity and sport for this purpose. Herodicus of Thrace was one of the more vigorous champions of physical exercise as a way to achieve improved strength and endurance. He developed an elaborate system of exercise called *Ars Gymnastica*. Celsus, in discussing hemiplegia and other paralyses, stated that although "a perfect cure is rare . . . gradual exercise and walking as much as possible" is necessary. He also suggested the use of exercise and games as valuable in caring for other medical conditions.

Galen, in his writings, also recommended the pursuit of physical activity in order to achieve good health. In fact, according to Licht in his book on *Therapeutic Exercise*, Galen reserved his "highest praise for the game of 'small ball' which corresponds roughly with our game of handball. 'The best exercise of all are those which can not only train the body but also delight the mind. For so much in them can move the mind that many have been delivered from diseases solely by delight'."

During the Renaissance, gymnastics were advocated in many countries of Western Europe. In 1705 one of the earliest books dealing with medical gymnastics was written by Francis

Fuller, *Medicina Gymnastica* or *Treatise on the Power of Exercise with Respect to the Animal Economy*. Earlier, Ambrose Pare, the famous French surgeon, wrote on the value of exercising the limbs following fractures in order to promote healing and prevent further disability. Other authors including Andry, Tissot, Robelais, and Dally in France and John Hunter and John Abernethy in England also stressed the use of physical activity and exercise in the treatment of various disabilities.

Additional advocates of early mobilization and other pioneers in medical gymnastics appeared in Italy, Germany, Russia, and Sweden. It was in this latter country that Peter Henrik Ling developed and publicized the art and practice of gymnastics on a scale that was to achieve a great deal of popularity both in Sweden and in other countries. In 1845, J A L Werner, a German author, published a book dealing with the anatomical and physiological aspects of medical gymnastics for persons suffering from various types of deformities and disease.

Accounts of individuals who, once stricken with a disability, still managed to attain prominence despite their handicap (usually as a tribute to their own level of motivation and determination) are numerous but anecdotal. However, the vast majority of disabled have met only disappointment and depression, stemming from an inability to achieve a harmonious level of personal adjustment and social acceptance.

Wars' Disabled

Early efforts to utilize sport in actively rehabilitating the war-wounded were initiated in England by Sir Reginald Watson-Jones for the British Royal Air Force. In Germany, Mallwitz introduced a program of gymnastics and sport in treating the war-injured. But in all these programs, sporting activities were confined strictly to amputees, other skeletal injuries, and the blind. It was considered inconceivable to assume that competitive sport could play a role in the rehabilitation of the paraplegic or, even more so, the quadriplegic. As recently as the Second World War, spinal-injured patients were considered by most members of the medical profession to be hopeless cases who, because of their limited survival, were felt to be unrealistic candidates for a rehabilitation program.

Improve Survival

Indeed, prior to World War II, simple survival was the main and, parenthetically, the all-consuming activity of the paraplegic and those that were destined to take care of him. During World War I, the average life expectancy of

a person with a spinal-cord injury was six to 12 months post trauma. By World War II, life expectancy had increased somewhat, but still was a disappointing two or three years following injury. With the development and increased availability of antibiotics and the greater awareness of the complications of prolonged bed-rest and immobility a great stride was taken to cut down on the morbidity and mortality resulting from infection, the major killer of the spinal-cord injury. However, improved survival resulted in ever-increasing numbers of bed-ridden and wheelchair-bound patients filling the wards of the general and chronic disease hospitals.

As the hostilities of the Second World War took its toll among the armies of the world, even more patients were added to this unfortunate group of people—the “handicapped survivor.” These increasing numbers of disabled persons resulted in a total morbidity and cumulative disability that had reached public health proportions. More and more medical and paramedical personnel, as well as more and more governmental and private agencies, began to turn their attention to this group and to their unique problems; and, as an outgrowth of the therapeutic endeavors of this group of professional and concerned lay people, many patients began to achieve an improved level of independence and began to return home and to the mainstream of life in their homes and communities.

Stoke Mandeville and Sir Ludwig Guttmann

One of the first physicians active in the early stages of this reorientation process was Sir Ludwig Guttmann, who was commissioned by the British government during the Second World War to try to develop a program to improve the lot of the handicapped and the physically disabled, particularly the spinal-cord injured. Dr Guttmann and his coworkers developed the first major center in Great Britain to direct its full attention to the rehabilitation of the handicapped and to their problems. This center was located at Stoke Mandeville, just north of London and, even today, remains a major facility for the rehabilitation and retraining of the spinal-cord injured.

The use of sports in the retraining and reconditioning of the patients at Stoke Mandeville Hospital developed as a natural consequence of the rehabilitative process. Participation in sports and in sporting-type activities was found to be less structured and, therefore, a more interesting form of exercise. Athletic activity was

not only less tedious to perform repetitively, but also resulted in an improved level of motivation and function among those patients that participated in the program.

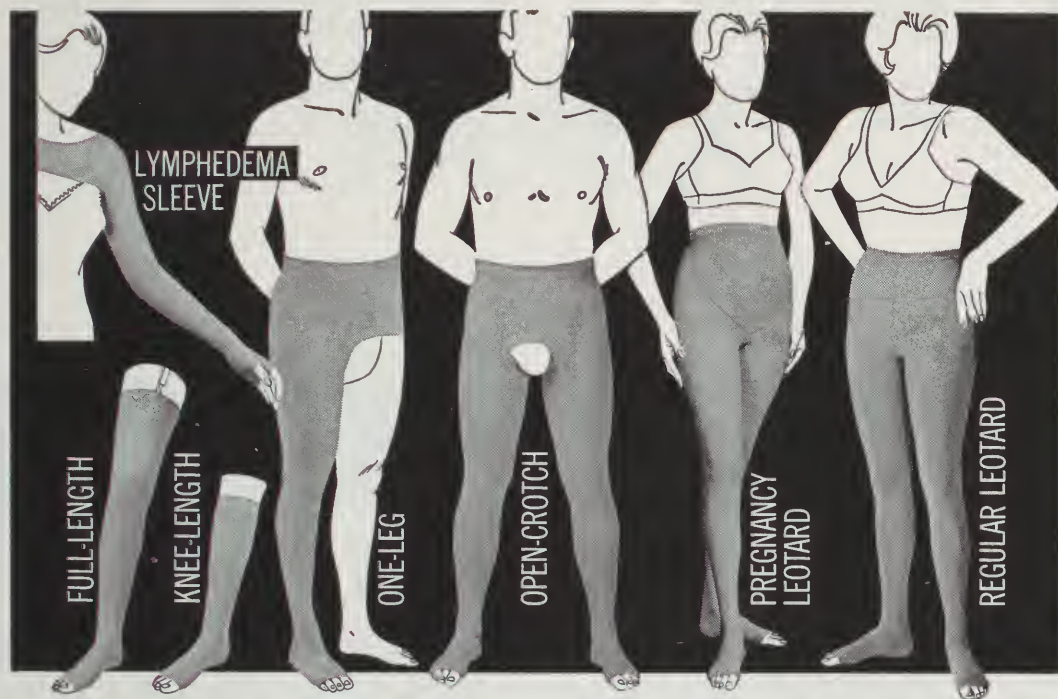
Thus, activities such as throwing and catching a medicine ball, javelin-throwing, and shot-putting were added to the more formal exercise program and were found to be of definite aid in helping the high paraplegic to regain his sense of balance (a sense which the able-bodied usually takes for granted). Archery, which requires a fair degree of physical exertion, as well as good balance, was found to be a readily adaptable form of physical activity for the wheelchair-bound patient; indeed, the chair-bound paraplegic, once developing adequate skill, can compete on even terms with nondisabled archers. Team sports, such as wheelchair polo and wheelchair basketball, proved to be of great value in developing a higher level of coordination, endurance, and agility. Further, these team activities served as extremely powerful motivational forces in the rehabilitative process for large numbers of patients. Not only were pure physical benefits obtained, but social expression and interaction were also achieved. Thus, the early groundwork was laid for the ultimate return of the severely handicapped to society and to social living.

The United States

Meanwhile, in the United States, prompted by the same problems that faced the British government relative to the handling of the ever-increasing numbers of disabled veterans that were saturating the available rehabilitation and vocational training centers, various federal and private agencies began to increase their resources and to expand their programs for rehabilitating more quickly this group of patients. Here, too, sports were rapidly appreciated to be a valuable adjunct to the more formal retraining programs.

Wheelchair basketball rapidly caught on in popularity among the returning veterans, many of whom had played prior to entering the military and becoming disabled. These players readily adapted the rules and regulations of official basketball to their own needs and, soon, competitive games among these disabled veterans began. Initially, the participants were primarily composed of war-injured paraplegics; but, as participation in the games increased in popularity, the range of disabilities also grew to include post-polio patients, amputees, orthopedic patients, and other similarly limited neuromuscularly impaired.

Continued next month



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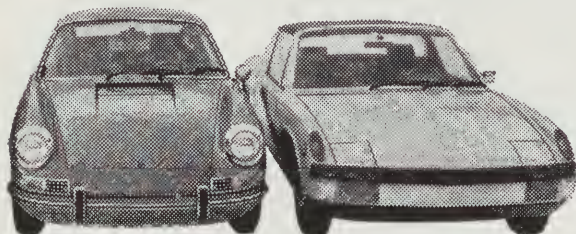
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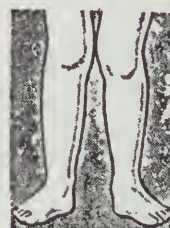
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Some Advances in the Diagnosis of the Mucopolysaccharidoses

JACK W BOWERMAN MD

Assistant Professor of Radiology
Johns Hopkins Hospital
Baltimore

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Information and reprint requests to Dr Bowerman at 601 N Broadway, Baltimore, Md 21205.

The recognition of a patient with strange physical features and retardation of physical or mental growth is often just a prelude to further work in the case of the mucopolysaccharidoses. Because the diagnosis of a mucopolysaccharidosis (mps) is often based on the teamwork of the radiologist, pediatrician, geneticist, orthopedist, biochemist, and cytologist, it is useful for each member of the team to consider certain work that influences the diagnostic process.

The basic radiological findings are familiar to many of us and will not be reviewed here. It is sufficient to say that the specificity of the radiological findings is being challenged as more and more separate conditions are disclosed. The diagnostic procedures that are possible apart from radiology are of critical importance. The present report is an effort to gather information regarding these procedures. The report is arbitrarily divided into comments on urinary, cellular, tissue, and amniotic fluid aspects in addition to comment on some recent concepts of mps disease.

Cellular Advances

In 1941 Reilly described the presence of cytoplasmic granules in the leukocytes of patients with the Hurler syndrome.¹ Such granules stain a dark lilac color with the Giemsa-Wright technique.

In 1965 fibroblasts were cultured from skin biopsies in three Hurler patients by Danes and Bearn.² A histochemical method employing a toluidine blue-O stain for the detection of mps showed that 60-90% of these cells contained metachromatic granules in the cytoplasm. Control cells showed a 2-6% incidence of metachromatic granules. (It should be explained that the use of the term "metachromatic," at least in the sense that it was used by Paul Ehrlich, refers to the ability of a substance to stain in a color different from that of the stain employed. In the

case of a blue stain such as toluidine blue, the metachromatic granules will stain in shades of red.)

The discovery of cytoplasmic granules in fibroblasts was heralded widely as a useful tool in the identification of suspected mps patients. Doubt was cast on the effectiveness of the Danes-Bearn method in work done four years later. Milunsky and Littlefield reported 17 diseases showing metachromatic granules in fibroblasts.³

In addition they noted that the staining reaction was positive, not only in the presence of mps, but with polypeptides, lipids, nucleic acids, and metaphosphates. Multiple cell culture factors appeared to affect the staining reaction as well, such as the time that cells remained in culture, the type of tissue culture growth media used, and the pH of the culture-growth media mixture. Similarly Taysi et al contributed further information about the incidence of metachromatic granules. They showed that 27% of control skin biopsy fibroblasts had metachromatic granules in a sample of hospitalized children with various diagnoses.⁴

Urine Findings

In 1957 Dorfman and Lorincz identified the excretion of an acid-mps in the urine in the Hurler syndrome.⁵ Since then the urine tests for mps have occupied a central position in the support of clinical diagnosis. A 1963 report by Robins et al of two siblings with Morquio's disease is of interest regarding laboratory studies and their interpretation.⁶ A seven-year-old girl and her one-year-old sister had Reilly bodies in their polymorphonuclear leukocytes. The urine studies were of two types: 1) a determination of 24-hour mps excretion expressed as mgs of glucuronic acid, and 2) the use of paper chromatography to qualitatively identify the mps types.

A normal range of glucuronic acid for adults was given as 2.7-7.3 mgs of glucuronic acid per 24 hours. The normal range for children was 1-15 mgs. The seven-year-old patient excreted 28 mgs per 24 hours. Both girls excreted a high proportion of keratosulphate. The authors point out

that several conditions other than mps can alter normal mucopolysaccharide excretion. A decreased renal function will lower mps excretion values. Rheumatoid arthritis, systemic lupus erythematosus, epidermoid carcinoma, leukemia, lymphoma, multiple myeloma, and severe liver disease will increase mps excretion.

Since this time advances in the methods of urinary mps diagnosis have included the development of a rapid screening test to detect an increased mps content as well as more elaborate methods of mps identification, separation, and quantification by electrophoresis and column chromatography.⁷ The procedures currently performed in many biochemical laboratories are as follows:

1) A screening test to answer the question: Is an abnormal amount of mps present in the urine? This test is also called the cetylpyridinium chloride (CPC) test because this quaternary ammonium salt is used to form an insoluble precipitate with the negatively charged mps. The degree of optical density of the turbidity produced by the precipitate is then measured in a spectrophotometer and related to similarly prepared standards.

2) An mps quantification test to answer the question: How much mps is produced in the urine in a given time? As mps is composed in part of monosaccharide units, a measure of a monosaccharide unit or derivative will relate to the mps quantity. The mps-CPC precipitate is dissolved so that an oxidative reaction can then be made on the mps. Carbazole is used for this purpose in the method of Bitter and Muir producing an oxidized derivative of glucose (C₆H₁₂O₆) known as glucuronic acid or uronic acid (CHO-CHOH₄-COOH). As described here, one normal range of values for children has been established at 11-15 mgs per 24 hours. If a 24-hour sample of urine cannot be obtained, a useful reference to the creatinine excretion in the urine available can be made with a resultant estimation of the 24-hour volume.

3) Electrophoretic and chromatographic separation of specific mps fractions to answer the questions: Which mps or mps' are present and in what proportion or quantities? Generally these procedures begin with the preparation of an ultrafiltrate-concentrate of mps by using vacuum apparatus. Samples of test mps can then be applied to cellulose strips, for electrophoresis or to exchange resin in columns for chromatography. In both methods, migration patterns are compared to those of known standards of specific mps in the same test. With the cellulose acetate strip method, the zone of mps can be stained

with Alcian blue and subjected to optical density measurements for semiquantification. In the column chromatography method, each resin volume is eluted and again an optical density system of measurement evolves. A commonplace resin choice is known as Dowex which is named for the Dow Chemical Company exchange resin.

A detailed study of the urinary mps fractions in the mucopolysaccharidoses was reported by Kaplan.⁸ He suggested that diagnosis and classification of these conditions can be made on the basis of the mps type and proportions present in the urine. For example, patients with a predominance of heparansulfaturia belong in the Sanfilippo (MPS III) category. Those who have keratansulfaturia are Morquio (MPS IV) patients. Those with isolated dermatansulfaturia are placed in the Maroteaux-Lamy (MPS VI) category. Those with a mixed mpsuria consisting of equal amounts of heparansulfate and dermatansulfate are Hunter (MPS II) patients. Patients with a mixed mpsuria in which the fraction of dermatansulfate clearly exceeds the fraction of heparansulfate belong in the Hurler and Scheie groups.

Tissue Advances

Work done directly on tissue samples and on cultures of fibroblasts obtained from skin biopsies of mps patients has contributed heavily to progress in diagnosis of the mucopolysaccharidoses. In 1964 Antonopoulos et al developed a technique for the detection of mps in tissues at the microgram level.⁹ In hepatic and renal tissues of Hurler patients, Van Hoof and Hers noted a deficiency of a specific beta-galactosidase.¹⁰ Similarly this deficient enzymatic activity was detected in subsequent studies on cultured fibroblasts of two patients with the Hunter syndrome by Gerich.¹¹ He incubated the Hunter patient cells with a specific substrate. The patients, who were nine- and eight-year-old brothers, had 25% and 33% of the normal mean value of galactosidase activity.

Knowing that mucopolysaccharide is a sulfated material and is the only large molecule of a fibroblast to take up inorganic sulfate, Fratanoti et al made a comparison of the labeling patterns of radioactive sulfate incorporation into normal and mps fibroblasts.¹² Skin obtained at biopsy or foreskin specimens obtained at circumcision were cultured and incubated with radioactive sulfate in two normal infants, one normal adult, one Hurler infant, and one Hunter adult. The isotopic incorporation patterns showed that the mps patients could synthesize and secrete labeled mucopolysaccharide, but had prolonged label disappearance times. This suggests the possibility

of an inadequate degradation of mps in the abnormal patients.

Amniotic Fluid

The establishment of amniocentesis in antenatal obstetrics led to the first antenatal diagnosis of the mucopolysaccharidoses. Fratanoti et al applied the technique of $^{35}\text{SO}_4$ incorporation in amniotic cells taken from two women who had previously borne children with an mps disease.¹³ Like the response obtained earlier with cultured fibroblasts, they showed that amniotic cells had a prolonged uptake of labeled sulfate. Metachromatic granules were noted in these cells as well.

A second method of establishing an antenatal diagnosis of an mps disease was published in the work of Matalon et al.¹⁴ They showed excessive amounts of dermatansulfate and the presence of heparansulfate in amniotic fluid, thus making possible a diagnosis of the Hurler syndrome. Since the fetal urine is the likely source of the measured mps, it seems reasonable to assume that similar assays of amniotic fluid may yield other mps diagnoses. As the amount of mps in amniotic fluid is normally highest in the early months of pregnancy, Danes et al suggested that serial amniocenteses may be needed to firmly establish the diagnosis of an mps condition.¹⁵

Recent Concepts

Both McKusick and Spranger have considered mps diseases without mucopolysacchariduria (mpsuria).^{16,17} Similarly Langer and Leroy et al have reported either mps patients or patients with a condition resembling a mucopolysaccharidosis without mpsuria.^{16,18} The entire issue of nosology in the mps diseases including further citations of mps disease without mpsuria is included in an article by McKusick.¹⁶

The work cited by Leroy et al¹⁸ is a useful example of the mps-like diseases that are now being recognized as separate entities and which were once wholly confused with previously described conditions such as Hurler's syndrome. Leroy and his coworkers studied two patients who had mental retardation and similar radiologic findings to those of Hurler patients. Several differences between this condition and Hurler's disease were noted.

Importantly, no mpsuria was detected and the degree of mental retardation was much greater in the two patients. They had an earlier and more severe growth retardation, no corneal opacities, no hirsutism, and lacked Reilly bodies in their lymphocytes. Skin biopsy fibroblasts, when examined with phase contrast microscopy, showed

a large number of dark cytoplasmic inclusions. Such inclusions were not found in fibroblasts from control and mps patients. The inclusions gave rise to the name *I-cell* or *Inclusion cell disease*.

A reason for considering the mps conditions in categories of "focal mucopolysaccharidosis" and "generalised mucopolysaccharidosis" is put forth in a report by Spranger et al.¹⁷ This report is an interesting focal point of the multiple avenues of investigation employed in the current mps diagnostic process. As in the efforts of Leroy et al, the authors recognized a previously undescribed form of dwarfism with radiological findings similar to those of the Hurler and Hunter syndromes. The condition was named geleophysic dwarfism because of the pleasant natured facial appearance of the three known patients (Gr. geleos=laughter and Gr. physikos=natural, hence a state of natural laughter). Hepatomegaly and cardiomegaly were present in two of the three patients. In addition to cardiomegaly, one of the children had thickening of the pulmonary valve and severe mitral stenosis. A homozygous recessive gene was assumed to be present; accordingly, the parents were advised of a provisional recurrence risk of 25%. The focal nature of this condition rests on the demonstration of dermatan sulfate in hepatic and cardiac tissue and the absence of abnormal mps in fibroblasts and in the urine. An outline of the investigations applied in this report follows:

- 1) The urinary excretion of acid-mps as measured by column chromatography and the quantitative estimation of uronic acid were normal in one patient.
- 2) Fibroblasts in tissue culture did not store excess acid-mps.
- 3) Cultured fibroblasts did not show an abnormal uptake of radioactive labeled sulfate.
- 4) The enzyme activity measured in fibroblasts and in hepatic cells showed normal amounts of beta-galactosidase, hexosaminase, and alpha-fucosidase.
- 5) Histology of hepatic tissue showed focal groupings of swollen hepatocytes.
- 6) Hepatic cells showed metachromatic staining with toluidine blue.
- 7) A histochemical study of hepatic and cardiovascular tissue showed dermatan sulfate.
- 8) Electron microscopy of storage material in hepatocytes showed a fine reticulogranular appearance and confinement of that material in membrano-vesicular bodies.

Summary

Several achievements have led to progress in the investigation of mucopolysaccharide abnormalities. Advances in tissue culture methods of fibroblast growth have contributed to the detection of micro-quantities of mps, the histochemical demonstration of increased amounts of specific mps, the recognition of normal and abnormal patterns of radioactive sulfate uptake, and the demonstration of decreased enzyme concentration in cells from mps patients.

Progress in amniocentesis has resulted in the antenatal diagnosis of mucopolysaccharidosis by two separate methods. In one technique, the diagnosis of a Hurler child and a Hunter child was made on the basis of an abnormal uptake of $^{35}\text{SO}_4$ in cultured amniotic cells. In a second method, amniotic fluid was found to contain increased levels of dermatan sulfate as well as the presence of heparan sulfate enabling a diagnosis of Hurler's syndrome. Phase contrast microscopy has been used to examine cells in a condition mimicking Hurler's syndrome. Cytoplasmic inclusions were noted and a new disease was recognized and named for the inclusions as I-cell or inclusion cell disease. The concept of a "focal mucopolysaccharidosis" has gained impetus. In such a condition, only certain tissues of the body have mps derangements and mpsuria may be lacking.

Finally, it is clear that there are no prescribed rules limiting the investigation of mps diseases or conditions resembling such diseases. Urine and amniotic fluid and cutaneous, hepatic, and cardiovascular tissues may hold further answers to questions posed in the laboratory.

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Ten Golden Rules for Good Health

As a basic element of its national health education campaign, the American Health Foundation recently formulated a list of "Ten Golden Rules for Good Health." Brief and easy to remember, each rule is a kind of triggering mechanism, designed to encourage, motivate, and focus attention on highly desirable health maintenance practices. The rules are:

- 1) Have a checkup every year.
- 2) Be a nonsmoker.
- 3) Drink in moderation
- 4) Count each calorie
- 5) Watch your cholesterol.
- 6) Learn nutritional values.
- 7) Find the time for leisure and vacations.
- 8) Adjust to life's daily pressures.
- 9) Develop an exercise program.
- 10) Understand your physical assets and limitations.

Through repetition in various media and literature, AHF believes that its Ten Golden Rules can contribute to the general public awareness of what preventive medicine is all about.

PEDIATRIC REFERRAL PATTERNS IN MARYLAND

OSCAR C STINE MD

Associate Professor of Pediatrics

University of Maryland School of Medicine

Baltimore, Md 21201

In cooperation with Maryland Chapter, American Academy of Pediatrics.

Information and reprint requests to Dr Stine.

THE PROBLEM

Planning for hospital and clinic facilities must include consideration of special requirements for diagnosis, treatment, and management of the diseases and disorders which befall the children who are being served. The physician who gives primary health care to children is most frequently the one who decides where the child will obtain highly specialized diagnostic and treatment services that are beyond the capacity of the usual doctor's office or the usual home.

The present patterns of referral of children to health facilities in Maryland by physicians giving primary office care determine whether a special facility is crowded or is only rarely used. Crowding may mean that some children are being served later than desired, while an investment in unused facilities is expensive to the community.

We may assume that medical centers, hospitals, and clinics expand their facilities in a step-wise manner by the addition of new policies, new equipment, and new staff. A new policy will address itself to an age group and to a problem or a set of problems. New equipment is designed for specific diagnostic or treatment procedures. New staff is qualified to act or function for certain age groups or problems. Referring physicians select different facilities for different diseases and for different stages in the care of disease.

The principal stages of care of a disease may be described as diagnosis, short-term care, and long-term care. Diagnostic procedures might be divided into those that are primarily medical in orientation and those that are psychological, social, or educational in nature. Hospitalization is a very important aspect of referral which may be divided into short-term and long-term hospitalization. A separate category for long-term follow-up by a specialist or a specialty clinic may be distinguished from long-term hospitalization.

METHOD

We studied the first choices of physicians for referral of patients to health facilities by a questionnaire which lists 20 diagnoses. Diseases were selected to represent several organ systems, several etiologies, several degrees of severity, and chronicity. We asked the physician to indicate the hospital or clinic to which he would refer a child with a given problem for each stage of care relevant to that diagnosis. Table 1 contains the two-page instrument.

It would be desirable, but costly, to select a representative sample of physicians in the State of Maryland. We chose to circulate the questionnaires to members of the Maryland Chapter of the Academy of Pediatrics, trusting to the interest of physicians to complete a rather demanding questionnaire. Fifty-one physicians responded. Nine pediatricians in administrative and teaching positions saw that their answers were not applicable and returned blank forms. Three partnerships responded jointly. Not all spaces in the questionnaire were filled.

The proportion of first choices that were attributed to each hospital was calculated by hospital and diagnosis. A number of questions may be answered by examining these relationships:

- 1) Do referral patterns change for different stages of disease?
- 2) May hospitals be described in terms of referrals received: "diagnostic centers" while others may be described as "long-term care facilities"?
- 3) Do medical facilities differ in the diseases referred to them?
- 4) Do referral patterns suggest opportunities for better or more efficient distribution of services?

LIMITATIONS OF THE STUDY

Care should be used in interpreting the results of this study because of the limitations of our sampling procedure. Although the sample was sufficient to receive reported referrals to more than 31 hospitals, as well as local health departments and voluntary agencies, it cannot be used as a representative sample of physicians in

TABLE 1: QUESTIONNAIRE CONCERNING ESTIMATION OF REFERRALS FOR 20 SELECTED PROBLEMS

Study of Referrals to Health Facilities for Children
Please write out Name of Facility at least once — use distinguishing initials thereafter

Condition requiring Consultations, Special Procedures or Referrals	Choice	Medical Diagnostic Facilities	Social and Psychological Diagnostic Facilities	Short-term Hospital Care	Long-term Hospital Care	Long-term Follow-up of Chronic Problem
1) Failure to thrive	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
2) Positive Tuberculin Skin Test in 4-Year Old Child	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
3) Suspected leukemia	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
4) Suspected brain tumor	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
5) Adolescent with diabetes	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
6) Severe learning problems or school underachievement but not retarded	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
7) Adolescent suspected of drug abuse	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
8) Cerebral palsy with atrophy of one limb	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
9) Unusual form of seizures	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
10) Child with repeated seizures, sometimes without intervening consciousness	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
11) Child with abnormality possibly due to chromosomal defect	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
12) Child in need of adenoidectomy	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
13) Child with unusual speech problem	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
14) Child with congenital heart disease potentially needing cardiac surgery	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
15) Newborn with diagnoses of suspected tracheo-esophageal fistula	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
16) Child with Croup possibly in need of tracheostomy	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
17) Child with asthma reaching the points of dyspnea and exhaustion	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
18) Child with pyloric stenosis	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
19) Child with hydronephrosis	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....
20) Child with inguinal hernia	1st.....	.....	.....	.....	.....	.....
	2nd.....	.....	.....	.....	.....	.....

Maryland. It is biased by self-selection of the responding physicians. It is limited to members of the Maryland Chapter of the Academy of Pediatrics and does not reflect referral patterns from general practitioners.

The questionnaire also sampled the problems that occur among children and does not reflect all problems experienced by children. The problems studied in the questionnaire do not represent the most common problems in pediatrics or

the most common problems requiring referral; they were selected to illustrate patterns of referral for problems that have characteristic needs known to pediatricians.

Some of the problems included in the questionnaire occur much more frequently than others among children in the State of Maryland and some of the problems not included in the questionnaire occur many times more frequently than those included. This means that the questionnaire reflects the capacity of an institution to attract referrals for a given problem rather than to estimate the number of children referred to that institution over a period of time.

Because of these limitations the most valid comparisons are made between categories in the questionnaire and within the groups of referrals reported to individual hospitals. In these ways comparisons between stages of care are useful. Differences in distribution of these diseases to a given hospital give a profile of that hospital.

RESULTS

Referral Patterns for Different Stages of Disease

Arranging diagnoses in the order of the frequency with which they were referred to a hospital in one of the five stages of care produced the lists in Table 2. (The lists are limited to the six diseases reported most often.) Leukemia is a leading example of referral in all five stages of care. Under diagnostic services, the special requirements of several diseases become evident: congenital heart disease and seizures clearly need expensive diagnostic equipment and are regularly reported as referred.

Failure to thrive, severe learning problems, and speech problems clearly have major social and psychological aspects requiring evaluation for management. Pyloric stenosis and inguinal hernia are recorded among the leading six referred diagnoses for short-term hospital care. The listing under long-term care of leukemia, failure to thrive, repeated seizures, and brain tumor under long-term care and long-term follow-up emphasizes that care in these stages is required by the chronicity of the disease, the effect upon the family, and the demand for specialized equipment or knowledge.

Referrals for Medical Diagnostic Services

The sample of questionnaires revealed 625 reports that a pediatrician would refer children with the 20 given diagnoses to health facilities for medical diagnostic services. Table 3 shows the proportion of referrals which were designated to specific hospitals. The general outline shows

**TABLE 2: DIAGNOSES REFERRED MOST FREQUENTLY
FOR GIVEN STAGES OF CARE**
(Six Most Frequent in Rank Order)

Medical Diagnostic Procedures	
Congenital Heart Disease	
Seizures	Unusual Repeated
Unusual Speech	
Suspected Brain Tumor	
Suspected Leukemia	
Tracheo-esophageal Fistula	
Short-term Hospital Care	
Suspected Leukemia	
Adolescent with Diabetes	
Failure to Thrive	
Seizures	Unusual Repeated
Pyloric Stenosis	
Inguinal Hernia	
Long-term Follow-up	
Leukemia	
Seizures	
Brain Tumor	
Congenital Heart	
Failure to thrive	
Tuberculosis Skin Test	
Learning Problems	
Social, Psychological Evaluation	
Failure to Thrive	
Severe Learning Problems	
Speech Problems	
Seizures	Repeated Unusual
Suspected Leukemia	
Adolescent With Diabetes	
Long-term Hospital Care	
Leukemia	
Failure to Thrive	
Brain Tumor	
Congenital Heart Disease	
Adolescent Diabetes	
Seizures	

**TABLE 3: PERCENT OF REFERRALS FOR MEDICAL
DIAGNOSIS TO MARYLAND HEALTH FACILITIES**

Sample: 625 Reports on 20 Selected Problems

Health Facility	%
Johns Hopkins Hosp	26.9
University of Maryland	13.5
Children's Hosp of DC	12.6
Sinai Hosp	8.8
Frederick Memorial Hosp	2.6
Mercy Hosp	2.4
Greater Baltimore Med Cen	1.9
St Joseph Hosp	1.9
Baltimore City Hosps	1.6
Holy Cross Hosp	1.6
Montgomery County Hosp	1.6
Prince George's County Hosp	1.4
South Baltimore Gen Hosp	1.4
15 Community Hosps	<1
Local Health Depts	5.9
Other Agencies or Specialists	9.3

one hospital received 26.7% of the reports. This was twice the number of the second-ranking hospital. There are three intermediate hospitals receiving large numbers of referrals followed by a group of nine hospitals with numbers followed by the remaining hospitals of Maryland which are indicated as the first choice of referrals by a small number of physicians and possibly for a small number of diseases.

At the lower edge of the table separate figures indicate that an important segment of referrals for diagnostic services, 9.3%, are sent to other specialists or organizations other than hospitals. Local health departments received 5.9% of the sample. Although the number of diseases referred to health departments for diagnostic services is small, and although some health departments have minimal equipment for such services, their total impact on distribution of diagnostic services towards the State requires further inquiry.

Referrals of Children for Problems Requiring Social, Psychological, or Educational Evaluation

Pediatricians reported slightly fewer instances of referrals of children with the listed diseases for social or psychological evaluation. The outline of Table 4 shows that the largest hospital receives more than three times the number of referrals for these evaluations than the second-ranking hospital. Five other hospitals are major recipients of these referrals. Only seven other hospitals are indicated as recipients of referrals for this stage of care; and they only receive such referrals from a small number of physicians and possibly for a small number of conditions. The other agencies receiving referrals included a broad spectrum of health and welfare agencies and a number of public school systems. The important role of local health departments (14.5% of the referrals) must be noted.

TABLE 4: PERCENT OF REFERRALS FOR SOCIAL OR PSYCHOLOGICAL EVALUATION TO MARYLAND HEALTH FACILITIES

Sample: 225 Reports on 20 Selected Problems

<u>Health Facility</u>	<u>%</u>
Johns Hopkins Hosp	31.8
University of Maryland	9.0
Children's Hosp of DC	9.0
Sinai Hosp	7.8
Rosewood State Hosp	5.9
Frederick Memorial Hosp	4.3
7 Community Hosps	<1
Local Health Depts	14.5
Other Agencies	14.5

Referrals for Short-term Hospitalization

Examples of 366 referrals for short-term hospitalization are reported. The outline of Table 5 is similar to Table 3. Of course, the agencies

TABLE 5: PERCENT OF REFERRALS FOR SHORT-TERM HOSPITALIZATION

Sample: 366 Reports on 20 Selected Problems

<u>Health Facility</u>	<u>%</u>
Johns Hopkins Hosp	26.2
Children's Hosp of DC	12.4
Sinai Hosp	11.2
University of Maryland	9.0
Holy Cross Hosp	5.7
Prince George's County Hosp	5.7
Frederick Memorial Hosp	3.8
Washington County Hosp	3.6
Greater Baltimore Med Cen	3.6
St Joseph Hosp	3.2
Anne Arundel Hosp	3.0
Memorial Hosp, Easton	2.9
16 Community Hosps	<2.0

other than hospitals including the health departments do not receive referrals for short-term hospitalization. The seven hospitals that received between 2% and 6% of the sample can be noted in this figure as having a greater contribution to acute inpatient care than to difficult diagnoses or social evaluations. The large number of hospitals who receive a small number of referrals, according to this questionnaire and sample, are smaller hospitals in relatively small communities. The reader must be aware of the possibility that these hospitals may receive medical and surgical diagnoses which represent a small proportion of the list on the questionnaire but which comprise a large volume of admissions in the total experience of children in a region.

Referrals for Long-term Hospitalization

Long-term hospitalization is characteristic of some of the diagnoses on the question list and is a possible need of certain of the listed diagnoses. Our sample of pediatricians reported 196 instances in which they would make a referral of one of the 20 diagnoses (Table 6). The largest medical center, which includes a floor for chronically ill children and an institute for children with learning problems, receives more than three

TABLE 6: PERCENT OF REFERRALS FOR LONG-TERM HOSPITALIZATION

Sample: 196 Reports on 20 Selected Problems

<u>Health Facility</u>	<u>%</u>
Johns Hopkins Hosp	33.8
Happy Hills Home	9.7
Children's Hosp of DC	8.2
University of Maryland	7.7
Rosewood State Hosp	7.7
Frederick Memorial Hosp	3.8
Holy Cross Hosp	3.6
Sinai Hosp	3.6
Washington County Hosp	3.6
12 Other Hosps	<1
Other Agencies	7.1

times the number of reports than the second-ranking hospital.

The second-ranking hospital was formerly a convalescent home and is now a long-term care institution for a broad spectrum of diagnoses. It is one of three hospitals for chronically ill children in Baltimore. Children's Hospital of the District of Columbia ranks third. The University of Maryland Hospital and the State Hospital for the Mentally Retarded Children have equal proportions of the sample from this questionnaire. Referrals to Children's Hospital School and to Kernan's Hospital were mentioned in six instances for children with cerebral palsy and an orthopedic problem.

Long-term Follow-up

Long-term follow-up was reported for only 172 examples. Table 7 shows how they were distributed among 17 facilities when local health departments are shown as one facility. Comparing this figure with the preceding, it is clear that referrals for long-term follow-up are limited to a small number of facilities. The function of the local health departments in long-term follow-up is revealed to have special importance. The referral of 7.6% of the examples to Frederick Memorial Hospital is apparently related to its outpatient rehabilitation services.

TABLE 7: PERCENT OF REFERRALS FOR LONG-TERM FOLLOW-UP

Sample: 172 Reports on 20 Selected Problems

Health Facility	%
Johns Hopkins Hosp.	33.8
Children's Hosp of DC	15.7
University of Maryland	14.0
Frederick Memorial Hosp	7.6
Rosewood State Hosp	4.6
Sinai Hosp	4.1
10 Other Hosps and Agencies	<3
Local Health Depts	10.5

Selection of Hospitals for Specific Diagnoses

The preceding analysis reinforces the clinical impression that there is a great deal of specificity in the selection of a referral destination based upon both the disease itself and the stage of care. By enumerating all of the referrals for a given diagnosis in one stage of care we may calculate the percentage of those diagnoses which are referred to a particular hospital. Table 8 presents the proportion of selected diagnoses which have characteristic needs in each of the five stages of care as referred to the four major medical centers of the region. Additional notes have been made to illustrate the use of health department services for social and psychological evaluation of severe

learning problems and the long-term hospitalization of children with failure to thrive in a convalescent hospital.

Medical diagnosis of children with congenital heart disease at Johns Hopkins Hospital has a national tradition and is shown in this regional study as receiving 65.7% of the reported referrals in the sample. Correction of a tracheo-esophageal fistula is an extremely difficult procedure with a high mortality rate; Hopkins is reported to receive 52.9% of these referrals. In contrast short-term hospitalization for surgical correction of inguinal hernia in the same hospital is mentioned only 10.5% of the time. The extensive ambulatory services of that medical center are reflected in the 21.4% of children with unusual seizures and the 33.3% of children with brain tumors who would be referred by this sample for long-term follow-up.

Equal proportions of children referred for severe learning problems are reported for Johns Hopkins Hospital and University of Maryland Hospital. This reflects the capacity of the latter to compete for referrals that require social and psychological evaluations. The absence of referrals to Sinai Hospital for children with congenital heart disease for medical diagnosis or for children with severe learning problems indicates how it may not be necessary for a major center to prepare itself for all diagnoses in all stages of care. The number of children in contrast to the number of diagnoses referred to Sinai Hospital may be estimated by noting that 15.7% of the reported examples of referral of inguinal hernia are referred to Sinai Hospital. This is noteworthy because receiving 15% of a common procedure may result in a larger utilization of pediatric beds than a larger percent of rarer conditions.

Leukemia was referred by several pediatricians to the National Institutes of Health for medical diagnosis, short-term hospital care, long-term hospital care, and long-term follow-up. Adolescents suspected of drug abuse are referred by some pediatricians to psychiatric hospitals such as Brook Lane Hospital and Sheppard Pratt.

Another way of looking at the effect of special equipment or skills in handling certain diagnoses is to look at what proportion of the sample of referrals to a given hospital is related to a specific diagnosis. These proportions are presented in Table 9. Among those referrals reported for the Johns Hopkins Medical Center, 14.8% were for diagnosis of congenital heart disease and 14.2% were for hospitalization for leukemia. Only 2% of the referrals to that Center were for inguinal hernia.

TABLE 8: PERCENT OF ALL REPORTS ON GIVEN PROBLEM IN GIVEN STAGE OF CARE REFERRED TO SELECTED MAJOR FACILITIES

STAGE OF CARE PROBLEM Health Facility	Medical Diagnosis		Social-Psychological Evaluation		Short-term Hospitalization		
	Congenital Heart	Tracheo-esophageal Fistula	Failure to Thrive	Severe Learning	Pyloric Stenosis	Inguinal Hernia	Croup
Johns Hopkins Hosp	65.7	52.9	39.1	21.7	25.0	10.5	18.7
University of Maryland	15.7	11.7	8.6	21.7		5.2	6.2
Sinai Hosp		8.8	13.0		10.0	15.7	12.5
Children's Hospital of DC	2.6	17.6	8.6	8.6	5.0	10.5	6.2
Local Health Depts			8.6	30.4			

STAGE OF CARE PROBLEM	Long-term Hospitalization		Long-term Follow-up	
	Leukemia	Failure to Thrive	Unusual Seizures	Brain Tumor
Johns Hopkins Hosp	35.0	27.7	21.4	33.3
University of Maryland	10.0	11.1	28.5	25.0
Sinai Hosp	10.0			
Children's Hospital of DC	5.0	5.5	14.2	16.6
Happy Hills Home	5.0	33.3		

TABLE 9: PERCENT OF SAMPLE-REFERRED-TO-HOSPITALS REFERRED FOR STATED DISEASES

STAGE OF CARE PROBLEM Health Facility	Medical Diagnostic		Psychological Social		Short-term Hospital Care			Long-term Hospital Care		Long-term Follow-up	
	Congenital Heart	Seizures	Failure to Thrive	Severe Learning	Pyloric Stenosis	Inguinal Hernia	Croup	Leukemia	Failure to Thrive	Unusual Seizures	Brain Tumor
John Hopkins Hosp	14.8	7.7	11.1	6.1	5.2	2.0	3.1	14.2	7.1	5.1	6.8
University of Maryland	7.1	14.2	8.6	21.7		3.0	3.0	13.3	13.3	16.6	12.5
Sinai Hosp		1.8	14.2		4.8	7.3	4.8	28.5			
Children's Hospital of DC	7.5	6.3	8.6	8.6	2.2	4.5	2.2	6.2	6.2	7.4	7.4
Happy Hills Home								5.2	31.5		
Health Depts		8.1	5.4	16.2							

A comprehensive evaluation of children with severe learning problems is placed in high relief at the University of Maryland Hospital where 21.7% of all reported referrals were for severe learning programs.

Local health department clinics were designed as a preferred source of medical diagnostic procedures for 33.3% of the physicians reporting their first choice for referral of children with positive tuberculin tests; 39.1% of the adolescents with drug abuse; 20.6% of the children with severe hearing problems; and 10.8% of the children with speech problems. They were not mentioned as diagnostic facilities for suspected leukemia, suspected brain tumors, diabetes, heart disease, tracheo-esophageal fistula, croup, asthma, hydronephrosis, or inguinal hernia. They were the first choice for social and psychological evaluation for 33.3% of the reports on adolescent drug abuse and 30.4% of children with severe reading problems. Seizures, cerebral palsy, and speech problems were also frequently referred to them for social or psychological evaluation.

DISCUSSION

We see the low response rate as an indicator of the difficulty in completely filling out the questionnaire. Future work with such an instrument should be carried out by interview with consideration given for reimbursement of physician's time.

The patterns of referrals of children with dif-

ferent problems in different stages of care to several hospitals reminds us of the complexity of the professional practice of pediatrics. It is so complex that a physician may need to communicate with one hospital or health agency for a particular disease or even for a disease in a particular stage of care. The selection of a destination of a referral varies with the resources of the institution as well as the anticipated needs of a problem.

Major Medical Centers may not include care of all problems in all stages of care. This suggests the existence of a division of labor between hospitals. The medical centers receive high percentages of the complex and uncommon diseases. In contrast, some of the most common problems in health care of children appear with greater frequency as referrals to community hospitals and with relatively lower frequency to the medical centers.

Patients admitted to short-term care in small community hospitals do not have social and psychological consultation available as a regular part of the hospital services. Instead, that part of the evaluation is done prior to or following hospitalization in the local health department or by transportation to the medical center. Frederick Memorial Hospital is characteristically a community hospital but the presence of a rehabilitation center seems to permit it to attract some referrals as it becomes more of a medical center.

Outpatient services in major medical centers partly account for the comprehensiveness of care that includes social and psychological evaluations and long-term follow-up.

Frequent referral of problems by practicing pediatricians to local health departments was perhaps the finding least expected of this study. There seems to be a regional division of labor between medical centers and regional health departments where social and psychological evaluation and long-term follow-up for chronically ill patients are carried out near patients' homes by local health departments, while the medical centers are sought for comprehensive work-up of complex patients and long-term follow-up of those who need specialized attention.

In spite of the great cost of long-term hospitalization, pediatricians still seek long-term hospitalization in hospitals which are essentially designed to serve children for short-term illnesses. The questionnaire revealed a distinction made by some physicians between long-term hospitals and short-term hospitals. The former received referrals of chronic diseases and diseases in which child development or social problems are important factors.

Distinctions have been made in the past between acute and chronic disease services. Distinctions have also been made between primary-care hospitals and medical centers. Our findings which show differences for individual diseases and individual stages of care call for more precise definition of the functions which a facility is prepared to carry out. Among the problems listed in our instruments are some which are very specific and some which are broad and inclusive. A few of the specific ones may be grouped together for later studies as classifications of diseases and stages of care which require similar policies, personnel, and equipment.

For example, the problem of children with inguinal hernias might be grouped with other problems which are characteristically elective and which require comparable skill and equipment. In this way we may work towards a classification of pediatric conditions in which those conditions which require comparable policies, equipment, and personnel may be grouped in a category so that a health facility may explicitly state that they desire referrals for that category of conditions. Similarly, if a health facility does not choose to assemble staff and equipment for conditions requiring costly equipment or unusual skills, the facility may advise referring physicians that they do not choose to receive referrals in that category. Our questionnaire has

offered some concepts, some examples, and a vocabulary which we believe will stimulate more precise communication and more precise decisions in the planning and utilization of health facilities.

CONCLUSIONS

Referral patterns do change for different stages of disease. Medical diagnostic procedures are done in community hospitals, medical centers, and health departments. Social and psychological evaluation is less likely to be done in a community hospital and more likely to be done in a major medical center or in a local health department. Short-term hospitalization is characteristically accomplished in community hospitals except for the less usual and most life-threatening diseases such as tracheo-esophageal fistula and congenital heart disease for which medical centers are sought. Long-term hospitalization is achieved for some children in convalescent homes or the State hospital for the retarded. Chronically ill children receive long-term follow-up in centers with outpatient departments or for some diseases in local health departments.

Medical facilities differ widely in diseases referred to them. When individual diseases are studied, it is found that some major centers will not receive referrals for that disease in certain stages of care. Observations on the proportion of all referrals made to a hospital reveal that one diagnosis may account for a large proportion of the referrals to that hospital while other diagnoses make a minor contribution.

Opportunities for more efficient distribution of services might be seen in closer association between community hospitals and local health departments for cooperation in care of those diseases which require medical and social diagnostic services. Division of labor between hospitals can be observed in referral of chronically ill children to convalescent hospitals and in the absence of some diagnostic services from intermediate-size hospitals. The use of smaller community hospitals for commonly occurring conditions, or conditions that require basic equipment and skills rather than high specialized resources, permits a large number of children to be hospitalized near their homes and permits saving of costs not incurred by large investments for facilities to care for all diseases.

With this instrument, study of representative samples of pediatricians, family practitioners, and other specialists would describe utilization of facilities by children according to their problems. Further study is needed for building new facilities or for enlarging existing ones.

A Review of Some Newer Ideas in Burn Wound Management With Emphasis on the Use of a Burn Unit

GARDNER W SMITH MD

C T SU MD

Kiwanis Burn Unit and
Department of Surgery
Baltimore City Hospitals
Baltimore

Presented at the annual meeting of the Maryland Academy of Family Physicians on May 19, 1972 at Deep Creek, Md.

Information and reprint requests to Dr Smith at Baltimore City Hospitals, 4940 Eastern Ave, Baltimore, Md 21224.

The burned patient has presented both a challenge and a threat to physicians for centuries. A challenge because the initial physiologic derangements require the most meticulous management and the wound itself demands great ingenuity to achieve functional healing. A threat because the course is a protracted one both as regards survival from the acute injury and as regards ultimate successful rehabilitation. Because of the tremendous investment of time and energy required, many physicians would vastly prefer not to be involved in the care of the severe burn injury.

Yet involved we must be, for burns represent the leading cause of accidental death in preschool children and the second leading cause of accidental death in the age groups of 15 to 20 years and greater than 45 years. Someone must care for approximately two million burn injuries each year in the United States. In the State of Maryland alone there are some 42,500 burns annually with 175 deaths, about one half of these occurring in the Baltimore Metropolitan Area. Overall the mortality for burns is 4%, and this has remained unchanged for the past 15 years. It is also significant that 80% of these accidents occur at home and that about 50% involve victims less than four or over 65 years of age.

Newer Concepts in Burn Therapy: First-Aid

Many concepts in the first-aid care of burns are tried and true. In a book on home medicine published in 1881, it is sagely noted that "presence of mind in the sufferer is rare—but the best plan is to lie down and roll on the floor—screaming, of course, for assistance." Other good advice is proffered, such as not to fan flam-

ing clothing by running, and extinguishing the flames by wrapping in a blanket.

Unfortunately it is not yet common knowledge that major burns should not be anointed with anything, but rather simply covered with clean dressings and transported to a hospital for care. It has only recently been reappreciated that the severity of the injury depends, in part, upon the duration of exposure to heat, and therefore that the acute burn will benefit from rapid cooling. When practical, early rapid cooling of the burned area with cold water is an important feature of on-the-scene management. The first-aid treatment of burns is summarized in Table 1.

Table 1: First Aid For Burns

Remove Heat Source
Rapid Cooling
Airway
No Salves

Table 2: Fluid Replacement Formulae

Name	Colloid	Crystalloid	Free Water
Evans	1 ml/kg BW/% Burn	1 ml/kg BW/% Burn	2000 ml D5W
Brooke	0.5 ml/kg BW/% Burn	1.5 ml/kg BW/% Burn	2000 ml D5W
Moore	10% BW,	Mostly Colloid	
Moyer	None	15%	None
Baxter and Shires	None	4 ml/kg BW/% Burn	None

Newer Concepts in Burn Therapy: Fluid Resuscitation

The next phase in burn care is that of acute resuscitation. During the past 20 years a variety of formulae for fluid replacement have been developed and ardently supported. These have evolved from the Evans formula, which replaced fluid losses in the first 48 hours equally with crystalloid and colloid solutions, to the recent suggestions of Moyer and of Baxter and Shires which use only crystalloids in large volumes. The basic formulae are outlined in Table 2. The differences relate primarily to the amount of colloid employed, with greater total volumes required wherever less colloid is used. It has become clear that, in children at least, some colloid is necessary. Usually this is either plasma or albumin, but Dextran has its proponents. Blood replacement ordinarily is not necessary for early resuscitation.

Whichever regimen one chooses, two points are of paramount importance. In the first place, all of these programs are generally successful, so pick

one out, become familiar with it, and use it. Secondly, do not get locked into your formula. It is a guide for initiating therapy, but, whatever it is, it must be modified by monitoring appropriate parameters. The most important parameters (Table 3) are hourly urine output, central venous pressure, urine osmolality, and hematocrit. Fluid therapy must be altered to maintain all of these modalities within the normal range.

Table 3: Assessment of Fluid Replacement

Vital Signs
Hourly Urine Output
Central Venous Pressure
Urine and Serum Osmolality
Hematocrit
Blood and Urine pH
Body Weight

Burn shock is rather slow in onset, so fluid management must be prompt, but it is not emergent. If transportation to a care facility can be rapid, no fluid therapy is necessary. If, on the other hand, transportation will be delayed resuscitation must be initiated. Even in very major burns oral liquids may be used, especially a mixture of baking soda, salt, and water. Ideally intravenous crystalloids should be started if definitive therapy will be delayed for three hours or more.

Table 4: Body Weight Changes After Major Burns

Days After Injury	Gain or Loss	Amount	Controlling Factors
1-3	Gain	8-20%	Fluid Replacement
3-14	Loss	2% day	Fluid Mobilization
14 on	Loss	Variable	Caloric and Nitrogen Balance

Although body weight is difficult to follow in a severely burned patient, some concept of expected changes in this measurement is useful (Table 4). Clearly, with massive third-space fluid loss and adequate intravascular replacement, weight gain is not only expected, but desirable. The amount of weight gained in the first three days varies with the amount of fluid used for resuscitation, but gains of from 8% to as much as 20% are acceptable. After this period, weight loss is the rule and should occur at about 2% per day until the preburn weight is reached in about two weeks. Beyond two weeks weight loss represents negative nitrogen and caloric balance and will occur until balance is positive. This cannot be prevented, but should be minimized by caloric intake, control of sepsis, and prompt wound coverage.

The maintenance of adequate caloric intake may require intravenous hyperalimentation, but is best accomplished by the oral route using elemental diets by gavage if necessary. Another

source of weight loss is evaporative heat loss, but it remains debatable as to whether or not this can be controlled.

Newer Concepts in Burn Therapy: Topical Antibiotics

Perhaps the greatest recent advance in the care of burns relates to the use of topical antibiotics. Topical applications are not new, and a mixture of goat dung and yeast was strongly advised over 3,000 years ago. Unfortunately that prescription, like most of its successors such as tannic acid and prussic acid, was not a notable success. In 1964 both mafenide hydrochloride and aqueous silver nitrate were introduced, and the era of topical antibiotics was begun. A great variety of these agents are now in vogue and are listed in Table 5. The relative merits and demerits of the four most popular ones are outlined in Table 6.

Table 5: Topical Antibiotic Agents

Silver Nitrate
Mafenide Acetate (Sulfamylon)
Gentamycin Sulfate
Silver Sulfadiazine
Neosporin
Betadine
Silver Lactate

Whatever one's choice, and indeed the choice should probably be rotated occasionally, none of these agents is a panacea. Electrolyte and acid-base balance problems plague some of them, allergic reactions and toxicity are problems with others, and bacterial resistance crops up with still others. Two drawbacks apply to virtually all of these topical applications. The most serious is delayed separation of the eschar (not a problem with Betadine and Neosporin). Because of this, a delayed mortality has arisen when the slough finally occurs, and this has served again to emphasize the importance of early and expeditious wound coverage.

The second new problem is the emergence of opportunistic wound infections, especially viral and fungal. The common fungal burn infections are aspergillosis, candidiasis, and sporotrichosis; herpes is the viral offender. Indeed deep fungal invasion of the burn wound has increased in incidence from 5% to 30% with the use of topical agents. Despite these problems, however, the topical antibiotics have clearly saved lives and are now an integral part of the care of the burn wound.

Newer Concepts in Burn Therapy: Immunology

Recent advances in the field of transplantation

Table 6: Advantages and Disadvantages of Topical Agents

Factors Assessed	AgNO ₃	Mafenide	Gentamycin	Sulfadiazine
FDA Approval	Yes	Yes	No	No
Ease of Use	Messy	Easy	Easy	Easy
Pain on Application	Mild	Moderate	None	None
Sensitivity Reactions	None	5-10%	None	Low
Toxicity	None	None	Oto-nephrotoxic	None
Electrolyte Problems	Yes	No	No	No
Acid-base Problems	No	Yes	No	No
Eschar Penetration	Poor	Good	Good	Fair
Eschar Separation	Delayed	Delayed	Delayed	Delayed
Antibacterial Spectrum	gram + and -	gram + and -	gram -	gram -
Bacterial Resistance	No	No	Yes (Pseudomonas)	Yes (Klebsiella & Staph)
Methemoglobinemia	Yes	No	No	No
Inhibition of Epith Regeneration	No	Yes	Unknown	Unknown

have caused a great resurgence of interest in immune mechanisms and host defenses. Some of this information has, thus far in a fragmentary way, been applied to the care of burns, although very little is, as yet, of established clinical value. For many years reference has been made to "burn wound toxins," and attempts were made to combat these with convalescent burn serum.

Since neither the "toxin" nor the serum are specific, this therapy is ineffective. It has been noted that humoral immunologic factors, particularly complement, IgG and IgM, are depressed in the early phases of the acute major burn. However, they all return to normal by the end of two weeks. No specific host immunologic malfunction has been associated with these changes, and gamma globulin therapy has no effect on burn survival or on the incidence of burn wound sepsis. Cell-mediated, or delayed hypersensitivity, immunity is apparently altered by an acute burn, and phagocytosis appears to be depressed as well, but neither of these has as yet been correlated with the clinical course of the burned patient.

Thus far, the only clinical application of immunology to burn care has been the use of active immunization with a polyvalent *Pseudomonas* vaccine. This vaccine has had limited clinical trials and seems effective in decreasing systemic *Pseudomonas* sepsis, although it does not diminish colonization of the wound itself. Although practical applications are still largely in the future, immunology holds promise as one of the potentially most rewarding avenues of burn research.

Newer Concepts in Burn Therapy: The Respiratory Tract

The care of respiratory tract injuries associated with major burns has generated considerable re-

cent controversy. It has become clear that respiratory failure is the gravest single early complication of thermal injury; until recently, early tracheostomy was strongly advocated upon the least suspicion of respiratory problems. However, experience has shown that the morbidity and mortality associated with tracheostomy alone may be in the range of 45% and 5% respectively. Accordingly, this procedure is now withheld except for specific indications.

At least three mechanisms may be involved in the pulmonary insufficiency associated with burns. The most obvious is a direct thermal injury to the respiratory tract, or the inhalation of noxious fumes. A second mechanism relates to the pulmonary changes caused by all forms of shock. And finally, usually at a later stage, pneumonia and atelectasis may supervene.

Because of all of these potential pulmonary threats, meticulous tracheal toilet is essential in caring for all burn victims. Furthermore, pulmonary function should be carefully followed with blood gases and chest X-rays. Serial sputum cultures will permit identification and specific therapy for bacterial invaders. There is recent evidence that methylprednisolone sodium succinate in large doses may forestall the pulmonary effects of shock. In general, however, one may minimize respiratory deaths with meticulous pulmonary care and specific antimicrobial therapy.

Newer Concepts in Burn Therapy: Wound Coverage

It is now well known that burn victims rarely succumb during the initial phase of the injury, yet overall burn mortality was not altered by this concept of shock. Death was simply delayed and ultimately caused by burn wound sepsis. The use of topical antibiotic therapy has, indeed, improved these results. However, as noted, such

therapy delays separation of the eschar and late deaths now occur in association with the ultimately infected open wound. All of this has served to emphasize the importance of early wound closure, or at least coverage, and several new approaches have been directed at this problem.

One suggested approach is early primary excision and autografting. This has proved practical only for relatively small, full-thickness burns involving no more than 10% to 15% of the body surface area, but in this situation the results are excellent. With larger burns the trauma and blood loss associated with primary excision has resulted in a prohibitive mortality.

A more recent suggestion is the technique of tangential excision. This technique differs from primary excision in two ways. In the first place the entire thickness of the burn is not excised, but the area is simply shaved down with a knife or dermatome until capillary bleeding occurs regardless of the depth or the apparent degree of injury to remaining tissues. Secondly it is applicable to deep partial thickness as well as to full thickness burns. Finally it is imperative that any area of tangential excision be immediately grafted, using autografts if at all possible.

With extensive burns the availability of autogenous skin for coverage may become an insuperable logistical problem. One method of surmounting this is the use of mesh grafts. A meshed skin graft can be expanded to cover nine times the surface area which the intact graft could cover. However, healing is clearly dependent upon epithelialization and contraction and thus results in significant scarring. For this reason, such a technique is not applicable to cosmetically or functionally critical areas.

Temporary wound closure can be achieved with the so-called "biologic wound dressings." Both homograft and heterograft skin may serve this purpose. Homograft skin is usually viable and is very suitable material, but its use has been limited by availability. When homografts are applied, they must be changed every two or four days or they will become stuck. If one waits for rejection, the resulting slough is little improvement over the initial wound itself.

Because of logistical difficulties with homografts, heterografts, both porcine and canine, have become popular. In fact, the concept of heterografting is centuries older than allografting since the use of frog skin on burns was recommended in the Ebers Papyrus in 1560 BC. Pig skin is the commonest heterograft in use today. It may be obtained fresh and sterile, but is usually purchased in lyophilized form as a nonviable biologic dressing.

Concept of a Burn Unit

Having reviewed some of the newer trends in the care of thermal injuries, it seems appropriate to discuss the concept of a burn unit. Specialized units for special problems have proliferated in the past decade, and burn victims have profited from this idea. Initially the burn unit was conceived because of the need to provide protective isolation for burned patients in an attempt to control burn wound sepsis. Isolating an individual patient on a general ward is difficult, wasteful of space and equipment, and undoubtedly interferes with optimal nursing and physician care. It has serious psychological disadvantages as well. Therefore, it seemed reasonable to provide an isolated and protected area for a whole group of patients.

It has become apparent, however, that even in a germ-free environment the patient is not protected from his own organisms, so isolation is a relative matter. Truly sophisticated isolation techniques are also prohibitively expensive. However, although burn units were developed to provide isolation, many other benefits soon became apparent. The greatest of these was the clearly improved care that resulted from concentrating in one area all of the facilities and trained personnel necessary for the treatment of burns. Furthermore, such concentrated effort led to improved and productive research. Thus a burn center now may be defined as a self-contained unit with a full complement of highly trained personnel which is capable of providing total care for the burned patient. This care extends from initial resuscitation through definitive reconstruction to ultimate rehabilitation.

An outline of the facilities which should be available in a burn unit is presented in Table 7. Isolation usually consists of controlled access and the use of modified aseptic techniques. Atmospheric control is of some value and may be of varying degrees of sophistication. Because total care must be provided, facilities are included for the management of shock, for pulmonary ther-

Table 7: Burn Unit Facilities

Isolation (Controlled Access)
Atmospheric Control
Temperature
Humidity
Filtration
Positive Pressure
Water Baths
Operating Room
Recreation
Occupational Therapy
Physical Therapy
Research

apy, and for specialized wound management. Transportation of a burned patient to the general operating room entails both the risk of contaminating the burn wound and also the danger of contaminating the operating room.

Accordingly, a complete operating facility should be incorporated in the unit. Rehabilitation depends upon occupational and physical therapy and facilities for these functions should be included. Since recovery from a burn is a prolonged process, recreational opportunities are very important. And finally, a research laboratory is an essential adjunct to a productive burn center.

Table 8: Burn Unit Personnel

Physicians
 General Surgeons
 Plastic Surgeons
 Pediatricians
 Internists
 Psychiatrists
 Anesthesiologists
 Registered Nurses
 Practical Nurses
 Aides and Orderlies
 Psychologist
 Physical Therapist
 Occupational Therapist
 Social Service Worker
 School Teacher

Even more important than the bricks and mortar are the personnel of the unit. Table 8 lists many of those required. Some, such as physician consultants, psychologists, social workers, and school teachers may work only part-time in the area. Many others, especially physicians and nursing personnel, must be fully trained and full-time involved. It is estimated that, on the average, each burn victim requires 12 hours of nursing care daily. With a little mathematics, it soon develops that no fewer than 67 nursing personnel alone are necessary for a 20-bed burn unit. Clearly this is a very expensive undertaking, but it does pay off in results.

Who Should Use The Burn Unit and How

It was stated at the outset that some 42,500 burns occur each year in the State of Maryland. Obviously the great majority of these are treated either in a physician's office or in an Emergency Room. As another consideration, burn unit facilities are limited. There are only 16 such units in the entire United States, and the Kiwanis Burn Unit is the only one in the State of Maryland. With a capacity of eight beds, it can handle perhaps 80 to 100 burns annually or less than 0.2% of all such accidents in the State.

With these considerations in mind it is perhaps worthwhile to dwell on which burns should be hospitalized and which ones should go to a burn unit. Hospitalization should be advised whenever there is any suspicion of respiratory tract injury (Table 9). Victims with superficial burns involving more than 9% body surface area or with third-degree burns of more than 3% should be in a hospital. Other indications for hospitalization are electrical and chemical burns and burns with severe associated injuries. And finally, burns involving critical areas such as the hands, feet, face or genitalia are best managed in a hospital.

Table 9: What Burns Should Be Hospitalized?

Possible Respiratory Tract Injury
 Superficial > 9% BSA
 Deep > 3% BSA
 Burns of Critical Areas
 Electrical and Chemical Burns
 Severe Associated Injuries

Table 10: What Burns Should Go To A Burn Unit?

Known Respiratory Tract Burns
 All Deep Burns > 20% BSA
 Deep Burns > 10% BSA if age < 5 or > 50
 Deep Burns > 10% BSA with Associated
 Pulmonary, Cardiovascular, or Liver
 Disease
 Burns Needing Extensive Reconstruction
 Hands, Face, Genitalia

The most severe of the burns requiring hospitalization should be cared for in a burn unit (Table 10). This recommendation applies to all patients with known burns of the respiratory tract. All deep burns in excess of 20% of body surface area should be referred to a burn unit, as should deep burns in excess of 10% in victims less than five or over 50 years of age. Patients with burns of greater than 10% and associated pulmonary, cardiovascular, or liver disease should also be in a burn center. And finally, the special capabilities of a burn unit are especially adapted to burns of critical areas which will require extensive reconstruction and rehabilitation.

Conclusion

This article has presented something of an overview of recent and sometimes controversial aspects of burn wound management. Special emphasis has been placed upon the concept of a burn unit, with a description of the facilities and personnel involved. And finally, the use of a burn center has been discussed, pointing out that, while the majority of burn victims may be treated as outpatients, certain of them require hospitalization, and a select group of these deserve the specialized advantages of a burn center.

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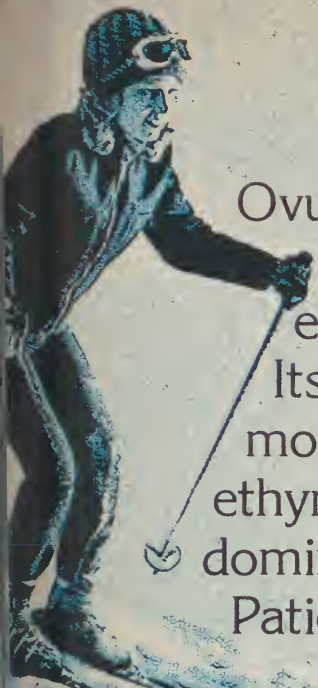
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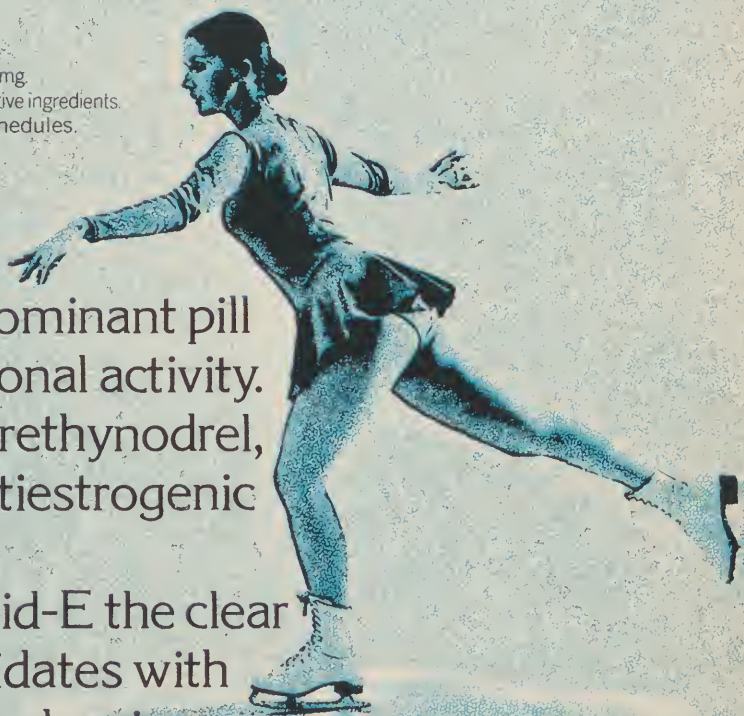
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Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain^{1,3} leading to this conclusion, and one² in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and

the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine; and decrease in T₃ uptake values; metyrapone test and pregnandiol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1963. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969.

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Bertram Pitt MD, **EVOLVING CONCEPTS OF MYOCARDIAL ISCHEMIA — A BACKGROUND FOR THERAPY**

C Richard Conti MD, **THE SYNDROME OF UNSTABLE ANGINA PECTORIS — A THERAPEUTIC CHALLENGE**

David T Kelly MD, and **Dean R Taylor MD**, **MYOCARDIAL INFARCTION — EVALUATION OF THERAPY IN 1973**

A panel discussion will follow in which all of the above will participate plus **Leonard Scherlis MD**, Professor of Medicine and Head of the Department of Cardiology, the University of Maryland School of Medicine.

THE PROBLEMS OF POLYARTHRITIS, a panel discussion moderated by **Mary Betty Stevens MD**, Associate Professor of Medicine, the Johns Hopkins University School of Medicine, will have as participants **Werner F Barth MD**, **Harry F Klinkfelter MD**, **Thomas M Zizic MD**, **Gaylord L Clark Jr MD**, and **Jack W Bowerman MD**.

CURRENT CONCEPTS IN THE THERAPY OF CONGESTIVE HEART FAILURE, a panel discussion moderated by **William J Kinnard Jr, PhD**, Dean of the School of Pharmacy, University of Maryland, will have as participants **Robert A Kerr, PharmD**, **John Young, PhD**, and **Anthony Manoguerra, PharmD**.

DISEASES OF THE COLON will be the title of a panel discussion on which **Bentley P Colcock MD**, Chairman of the Board of Governors of the American College of Surgeons and Senior Surgeon at Lahey Clinics, will speak on **DIVERTICULITIS**; and **Robert J Coffey MD**, Professor of Surgery at Georgetown University School of Medicine, will speak on **NEOPLASTIC DISEASES OF THE COLON**. Other participants on the panel will be **Arthur E Cocco MD**, **John N Diaconis MD**, and **J C Handelsman**, all of Baltimore.

WHY TREAT DIABETES will be the title of a discussion by **Marjorie Peebles-Meyers MD** of Detroit, Mich.

SEXUALITY AND THE PRACTICE OF MEDICINE will be discussed by **Mary S Calderone MD**, Executive Director of SIECUS (Sex Information and Education Council of the US). This will be the **Hundley Memorial Lecture in Gynecology**.

SELECTION OF DEFINITIVE THERAPY IN CANCER OF HEAD AND NECK will be the title for the first **Grant E Ward MD Lecture** to be presented by **Robert G Chambers MD**, Assistant Professor of Surgery at the Johns Hopkins University School of Medicine. The second part of this cancer panel will be on **CURRENT CONCEPTS IN THE TREATMENT OF CANCER**.

PROBLEMS OF SMELL IN MEDICAL PRACTICE will be the title of a discussion by **Robert I Henkin MD** of the National Institutes of Health.

NEWBORN EMERGENCIES will be the general title of a pediatric panel planned by **J**

Alex Haller MD and **Marvin Cornblath MD** of the Johns Hopkins and University of Maryland Schools of Medicine respectively. The main speaker at this session will be **Jens G Rosenkrantz MD**, Chief of Pediatric Surgery at the Childrens Hospital in Los Angeles.

A FAMILY PRACTICE program will consist of a panel presentation of interesting clinical cases by the staff and residents of the University of Maryland School of Medicine, demonstrating comprehensive medical care. Participants will be **Edward J Kowalewski MD**, Professor and Head of the Family Practice Program, **J Roy Guyther MD**, Associate Director of the Family Practice Department, **C Earl Hill MD**, Assistant Professor in the Family Practice Department, **Alva Baker MD**, Chief Resident in the Family Practice Center, and **Stephen Levin MD**, third year Resident in the Family Health Center.

Additional information about speakers and subjects for this 175th Annual Meeting will be published in the March and April issues of the Journal. A complete program will be sent to all members of the Faculty several weeks prior to the Meeting and to others upon request.

ALBERT M ANTLITZ MD, Chairman
Committee on Program and Arrangements

ART AND HOBBY EXHIBIT

ANNUAL MEETING OF THE
MEDICAL AND CHIRURGICAL
FACULTY OF MARYLAND
APRIL 25, 26, 27, 1973
BALTIMORE CIVIC CENTER

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1211 Cathedral St, Baltimore, Md 21201

1. Title of exhibit:
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 3. Electrical or other requirements:
 4. Name of exhibitor:
Please print
 5. Address of exhibitor:
 6. Telephone number of exhibitor:
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An Art and Hobby Exhibit will be held during the 175th Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to THE BALTIMORE CIVIC CENTER, Baltimore, between 9:00 AM and 4:00 PM on Tuesday, April 24. They must be removed on Friday, April 27 between 2:00 and 5:00 PM. The Faculty cannot carry insurance on exhibits, but utmost care will be taken of them. There will be a watchman on duty when the meeting is not in session. Exhibitors' personal policies will probably cover the exhibit. All entries should be submitted as early as possible.

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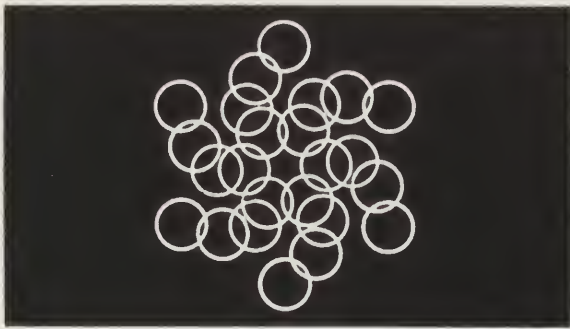
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From the Subcommittee on Alcoholism of the
Medical and Chirurgical Faculty of the State
of Maryland

alcoholism section

CRITERIA FOR THE DIAGNOSIS OF ALCOHOLISM

This article by the Criteria Committee, National Council on Alcoholism, is reprinted with permission from the American Journal of Psychiatry, Vol 129, pp 127-135, 1972, copyright 1972; the American Psychiatric Association; also from the Annals of Internal Medicine, Vol 77, pp 249-258, 1972; copyright 1972, the Annals of Internal Medicine.

Reprints of the Criteria are available from the National Council on Alcoholism, Publications Dept, 2 Park Ave, New York, NY 10016.

These criteria were compiled by a committee of medical authorities from the National Council on Alcoholism to establish guidelines for the proper diagnosis and evaluation of this disease. Criteria are weighted for diagnostic significance and assembled according to types: Physiological and Clinical (including major alcohol-associated illnesses) and Behavior, Psychological, and Attitudinal. Because early diagnosis is helpful in treatment and recovery, manifestations are separated into their earlier and later phases. There are brief discussions of recurrent and arrested alcoholism, cross-dependence, and the types of persons at high risk of alcoholism.

The problem of alcoholism has been receiving increasing interest in the past few years. Extensive treatment programs are being mounted, hospitals are beginning to accept patients for treatment, labor-management programs are attempting to identify alcoholic employees to give them special benefits and rehabilitation, third-party payments are being afforded by insurance carrier, and courts are making special disposition for rehabilitation. Therefore, it is important to establish a set of criteria for the diagnosis of alcoholism. To this end, the National Council on Alcoholism established a committee to prepare a set of criteria, to submit it for criticism and documentation by other experts, and to publish it for the guidance of those involved in the diagnosis of alcoholism.

At the outset, it became apparent that we had undertaken a formidable task, for, despite a great deal of work in the past, much of the literature is burdened by anecdotal material and special assumptions made a priori, and there is a dearth of scientifically controlled observations on the natural course of the disease. In addition, people of many disciplines have made observations from their own points of view, which may be hard to reconcile, and there are not a few who, by their definition of disease, have eliminated alcoholism from the category of disease. But any tendency to withdraw from the field was overcome by the urgency of the task, and the committee herewith presents the results of its deliberations.

Diagnostic criteria may serve several purposes. They may be used to ascertain the nature of a disease from a cluster of symptoms. This was not the main goal of the group. They may be used to promote early detection and provide uniform nomenclature, both objects of this endeavor. Criteria may be used to prevent over-diagnosis. This is important because of the psychological, financial, legal, and therapeutic implications in a diagnosis of alcoholism for the life of the patient. Criteria may be set for treatment purposes. Beyond indicating that a need for treatment exists, the committee believes that any indication of different modalities of treatment, except in broad terms, is beyond the scope of its mandate. Criteria may be set for prognosis; at present the prognosis for alcoholism is obscure.

Mainly, the committee expects the criteria to be used to identify individuals at multiple levels of dependency. The committee has endeavored to use objectively reproducible data that are obtainable from the patient, his immediate family, or his associates. These data have been weighted for their diagnostic significance. We have included material that would differentiate degrees of severity and that would allow for progression

of the disease, where that exists, without prejudging the possibility that cases of alcoholism may exist in which progression is not a factor.

All but one consultant believed that, in alcoholism, there generally is a progression of the disease, although this might not necessarily be reflected by continually increasing drinking. Many consultants have exhorted us to concentrate more on "early manifestations." The reader will note a separation into early, middle, and late effects, which is a general guide. Our first intent, however, is that the person who is diagnosed as having alcoholism surely fits into that category.

Nature of Alcoholism

The committee was unanimous in defining the disease of alcoholism as a pathological dependency on ethanol, as it is classified under Section 303.2 in the Diagnostic and Statistical Manual of Mental Disorders, second edition, of the American Psychiatric Association.

Aside from the legal difference between the distribution of alcohol and that of other drugs, there are important scientific differences. A drug is defined in two senses: it is a substance of use in medicine, and it is a habit-forming substance. It generally produces its effect in small quantities. Although alcohol does produce an effect with small quantities, it differs from other drugs in both senses in that large quantities over a long period of time are necessary for it to become habit-forming.

Another difference between alcohol and other drugs, particularly those of the opiate class, is the relative risk of addiction. Many people drink, but only 10% develop the psychological and physiological dependency on alcohol that can be categorized as alcoholism. With opiates, the risk of pharmacological addiction is considerably higher. Many alcoholics believe that they were alcoholics from their first drink, that their reaction to alcohol was different from that of others. These retrospective data are suspect until and unless a clear difference is established between these individuals and others. Family incidence of alcoholism and other factors may indicate a portion of the population at high risk.

Whether anyone who drinks a sufficient quantity over a sufficient period of time will develop alcoholism, whether a specific biochemical or psychological difference leads to alcoholism, or whether both conditions (with other as yet undetermined factors possibly turning the balance) are necessary to cause alcoholism has not yet been established. Thus, whether there is a continuous or discontinuous progression from drinking alcoholic beverages to dependency on alcohol

has not yet been clearly decided. Animal data suggest that anyone who drinks enough over a sufficiently long period of time will develop the signs of alcoholism. In the free state, however, neither all humans nor all animals choose the paths that lead to this condition. In establishing criteria for diagnosis, the committee wishes to avoid prejudging these issues of etiology.

On the other hand, once alcoholism is established, there is general consensus on its manifestations, and the committee thus feels it is appropriate to describe it as a disease, in agreement with the American Medical Association, the American Psychiatric Association, and other bodies. Alcoholism fits the definition of disease given in Dorland's Illustrated Medical Dictionary, 24th edition:

"A definite morbid process having a characteristic train of symptoms; it may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown."

Partial and intermittent forms of alcoholism pose some problems that will be treated separately. Isolated episodes of inebriation, even if they generate unfortunate consequences, are eliminated.

Divisions of Data

Data are assembled according to the type of material they represent. Therefore, there are separate data "tracks" — Track I: Physiological and Clinical, and Track II: Behavioral, Psychological, and Attitudinal. The Track II data are grouped together because behavioral manifestations, the easiest to determine and most objective to recognize, imply attitudinal and psychological manifestations.

There is no rigid uniformity in the progress of the disease, but, since early diagnosis seems to be helpful in treatment and recovery, manifestations are separated into "early," "middle," and "late." In addition to identifying early and late symptoms and signs, each datum was graded according to its degree of implication for the presence of alcoholism. Of course, some of the more definite signs occur later in the course of the illness. But this does not mean that people with earlier signs may not also have alcoholism.

Various terminologies for these signs have been suggested; we propose to weight them and group them into three "diagnostic levels," with those weighted as "1" being the most significant.

Diagnostic Level 1. Classical, definite, obligatory: A person who fits this criterion must be diagnosed as being alcoholic.

Diagnostic Level 2. Probable, frequent, indicative: A person who satisfies this criterion is under strong suspicion of alcoholism; other corroborative evidence should be obtained.

Diagnostic Level 3. Potential, possible, incidental: These manifestations are common in people with alcoholism, but do not by themselves give a strong indication of its existence. They may arouse suspicion, but significant other evidence is needed before the diagnosis is made.

Diagnosis

It is sufficient for the diagnosis of alcoholism that one or more of the major criteria are satisfied, or that several of the minor criteria in Tracks I and II are present. If one is making the diagnosis because of major criteria in one of the tracks, he should also make a strong search for evidence in the other track. A purely mechanical selection of items is not enough; the history, physical examination, and other observations, plus laboratory evidence, must fit into a consistent whole to ensure a proper diagnosis. Minor criteria in the physical and clinical tracks alone are not sufficient, nor are minor criteria in behavioral and psychological tracks. There must be several in both Track I and Track II areas.

Psychiatric Diagnosis

After a suitable evaluation, a separate psychiatric diagnosis should be made on every patient, apart from the diagnosis of alcoholism. Patients may suffer from schizophrenia, latent or overt; from manic-depressive psychosis, obsessive-compulsive neurosis, recurrent depression, anxiety neurosis, or psychopathic personality; or have no psychiatric constellation differing from normal. The diagnosis should properly be made in the dry state, since alcohol is anxiety-producing and can also bring out psychological mechanisms and traits that are not apparent without alcohol. In particular, the hallucinatory behavior induced by alcohol withdrawal is not to be equated with schizophrenic hallucinatory behavior.

Alcoholism With Intermittent or Recurrent Drinking

Intermittent or recurrent drinking may represent a phase in the course of alcoholism. This pattern should be noted separately. The same criteria control the diagnosis. In some individuals there are recurring episodes of inebriation that become more frequent over a period of years until a daily drinking pattern emerges. In many individuals daily drinking increases until the individual himself slowly becomes aware that physiological and psychological dependency exist. At this point periods of "going on the wagon"

may occur, with a resulting intermittent or recurrent pattern of drinking. For most drinkers, there are lesser or greater periods of time when, because of circumstances or the acute effects of alcohol, drinking is not possible. This pattern is not inconsistent with other drug dependency situations in which interruptions of use are commonplace and have been accepted without the necessity of making a separate category for them.

Even with a "steady" pattern of alcohol use, there are marked fluctuations in the blood alcohol level during each day. The patient with an alcohol problem, given free choice, does not, as one might assume, keep drinking to maintain a steady blood level of alcohol. It has been observed that men who were incarcerated for public intoxication for three-month periods had a total yearly alcohol intake and a total time available for drinking that may have been less than that of the "normal" drinker. Yet these men reported withdrawal signs and symptoms upon cessation of each drinking spree. Thus, there is, in some cases, an apparent persistence of the "alcohol addiction memory." The conditions that cause withdrawal signs and symptoms are not as yet fully understood.

Thus, where the practitioner has a patient whose drinking pattern consists of intermittent or recurrent drinking and in whom the appropriate diagnostic criteria are satisfied, the condition should be diagnosed as alcoholism (with the qualification as to pattern added if it seems important).

Alcoholism: Recovered, Arrested, or in Remission

Since alcoholism is relapsing and chronic, there are very few authorities who claim a complete cure. But there are many patients who, after a time of complete sobriety, have reordered their lives in a rehabilitative way and are completely able to perform complex and responsible tasks. There are also a few patients who have returned to "social" drinking or who have infrequent "slips" but who still function as rehabilitated persons.

Although these diagnostic criteria are not devised as a guide to prognosis, it is the opinion of the committee that a history of alcoholism in the past, followed by a significant recovery, should be taken into account as a guide to treatment, employment, and restoration of rights and privileges previously denied because of active alcoholism. Some members of the committee believed that total abstinence would not, in the future, turn out to be an absolute, final necessity for recovery from alcoholism. However, it was agreed that total abstinence, as a measure

of recovery, arrest, or remission was usually more easily measurable, definitive, and generally accepted than a change from "dependency" to "social" drinking. Thus, the committee agreed that the following considerations should determine the diagnosis of recovered, arrested, or remitted alcoholism:

Duration of abstinence

Concurrent AA attendance with full participation.

Concurrent self-administered and professionally guided deterrent medication

Resumption or continuation of work without absenteeism

No traffic violations

No substitution of other drugs

Although the committee did not choose at this time to assign definitive time values for any of these considerations, the recovery or remission gains in its validity with a progressively longer time. For abstinence alone to be the criterion, without other therapeutic activity, there needs to be a longer time period than if abstinence is combined with other criteria.

Alcohol Use

Diagnostic terms that define conditions that fall short of alcoholism are necessary because of the effects of alcohol on behavior. Although the term alcohol abuse has wide currency, we prefer alcohol use, accompanying this term with a description of effect. This leaves the term "abuse" for such situations as child abuse, animal abuse, or self-abuse, where there is an animate object of the abuse, and does not anthropomorphize alcohol, which, after all, is a chemical (the "neutral spirit"). The term misuse, we believe, also carries an unnecessary moral implication.

With Inebriation

Intoxication may be mild, moderate, or severe, or may lead to coma. Although alcoholics are frequently obviously intoxicated, mere intoxication is not sufficient for the diagnosis of alcoholism. Indeed the physician should be cautious in making a diagnosis of alcohol intoxication on the basis of a staggering gait, slurred speech, other neurological signs, and an odor of alcohol on the breath. In such cases, one must be sure to rule out diabetic acidosis, hypoglycemia, uremia, impending or completed stroke, and other causes of cerebral impairment. An alcohol breath test, determination of blood alcohol level, or serum osmolality measurement may assist in making a diagnosis of alcohol intoxication. A history from the patient and from family members or friends is usually helpful but must in itself be subject to evaluation. Alcohol intoxication must be

thought of in any person in coma; in addition, barbiturate and other sedative intoxication must be investigated: cross-dependence and cross-tolerance are common.

With Pathological Intoxication

In some individuals a small amount of alcohol will evoke violent, aberrant behavior. Pathological intoxication is an idiosyncratic response to alcohol and is separate from alcoholism.

Reactive, Secondary, or Symptomatic

Reactive, secondary, or symptomatic alcohol use should be separated from other forms of alcoholism. Alcohol as a psychoactive drug may be used for varying periods of time to mask or alleviate psychiatric symptoms. This may often mimic a prodromal stage of alcoholism and is difficult to differentiate from it. If the other criteria of alcoholism are not present, this diagnosis must be given. A clear relationship between the psychiatric symptom or event must be present; the period of heavy alcohol use should clearly not antedate the precipitating situational event (for example, an object loss). The patient may require treatment as for alcoholism, in addition to treatment for the precipitation psychiatric event: one may be able to confirm the diagnosis only in retrospect.

Alcohol and Anxiety

The effects of alcohol on the rising slope of the absorption curve parallel the four stages of anesthesia, and thus excited or uninhibited behavior may be shown with mild inebriation. But it also has been documented that, with large doses over a prolonged period of time, alcohol produces anxiety. Whether this bimodal effect occurs as a regular result of any amount of alcohol is currently being investigated. The progressive rise of anxiety with continued heavy drinking is responsible for many of the effects listed as minor criteria.

Cross-Dependence

Cross-dependence (or "cross-addiction") may begin iatrogenically or spontaneously with the use of any of the sedative class of drugs, barbiturates, or "minor" tranquilizers in an attempt to control the anxiety generated by heavy alcohol use or in the mistaken impression that pharmacological control of the anxiety will stop the alcohol use. Such cross-dependence is so common that it must be investigated in any person suspected of alcoholism.

In addition, the life style of persons who seek pharmacological "highs" is associated with heavy alcohol use *pari passu* with other psychoactive chemical materials. Such persons are at risk of alcoholism, and patients being investigated for

the diagnosis of alcoholism should also be evaluated for use of these materials.

Treatment programs for the use of other drugs engender a significant proportion of "instant alcoholics" who, having relinquished the other drugs, turn to alcohol and experience an unusually rapid onset of dependency. Thus, patients in this category should also be screened for alcoholism, and attempts should be made to prevent its onset.

Persons at High Risk

Epidemiological and sociological studies show that the following factors indicate high risk for the development of alcoholism. There is not complete agreement on the extent of risk for each factor.

A family history of alcoholism, including parents, siblings, grandparents, uncles, and aunts.²

A history of teetotalism in the family, particularly where strong moral overtones were present and, most particularly, where the social environment of the patient has changed to association in which drinking is encouraged or required.²

A history of alcoholism or teetotalism in the spouse² or the family of the spouse.³

Coming from a broken home or home with much parental discord, particularly where the father was absent or rejecting but not punitive.⁴

Being the last child of a large family or in the last half of the sibship in a large family.³

Although some cultural groups (for example, the Irish and Scandinavians) have been recorded as having a higher incidence of alcoholism than others (Jews, Chinese, and Italians) the physician should be aware that alcoholism can occur in people of any cultural derivation.⁵⁻⁷

Having female relatives of more than one generation who have had a high incidence of recurrent depressions.⁸

Heavy smoking: heavy drinking is often associated with heavy smoking, but the reverse need not be true.⁹

Recording the Diagnosis

If alcoholism as defined above is present, the diagnoses should be stated in this order:

Alcoholism: intermittent use, recurrent use, steady use (early, moderately advanced, far advanced)

Psychiatric diagnosis

Physical diagnosis

If major criteria or a sufficient number of minor criteria are not met, the diagnosis should be:

Suspected alcoholism: psychiatric diagnosis; physical diagnosis

Other diagnoses that can be made:

Alcohol use: reactive, secondary, or symptomatic; psychiatric diagnosis; physical diagnosis

Alcohol use with inebriation

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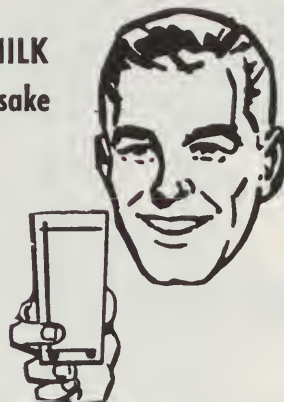
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Participation in the MEDLINE network will allow the librarian, or a physician in the library, by "conversing" with a computer via a type-writer-like terminal, to retrieve almost instantaneously references to the latest journal articles in his area of interest. The MEDLINE data base contains more than 400,000 citations to articles from about 1,200 major medical journals. This will greatly reduce the amount of time required to hand search bibliographies by the librarians. At the same time, it will permit the library to increase its services to the Faculty's members.

Once the terminal is operational in the library, the library should be able to offer same-day service on bibliography requests. The library should also be able to process far more requests than it has been capable of doing in the past.

It is hoped that the MEDLINE service will be fully operational from Med-Chi early in 1973. We are currently in the process of acquiring the terminal, and making plans to train part of the staff in its use. Updates concerning services available through MEDLINE and instructions on how to take advantage of these services will be forthcoming.

NEW ACCESSIONS — BOOKS (Arranged by Subjects)

ANATOMY

- QS Crouch, James E
4 **Functional human anatomy.** 2d ed. Philadelphia,
.C7 Lea & Febiger, 1972.

BIOCHEMISTRY

- QU Nelson, Gary J
85 **Blood lipids and lipoproteins: quantitation, com-**
.N4 **position, and metabolism.** New York, Wiley-
Interscience, 1972.

BIOLOGY

- HB Ehrlich, Paul R
875 **Population, resources, environment.** 2d ed. San
.E4 Francisco, W H Freeman, 1972.
QL Halstead, Bruce W
615 **Poisonous and venomous marine animals of**
.H2 **the world.** Washington, US Govt Print Off,
1965-70.
QH International Symposium on Molecular Biology,
506 5th, Baltimore, 1971.
.I 6 **Molecular and cellular repair processes.** Balti-
more, Johns Hopkins Univ Press, 1972.
QH Murdoch, William W
541 **Environment; resources, pollution & society.**
.M8 Stamford, Conn, Sinauer Associates, 1971.
QC Whiffen, David Hardy
451 **Spectroscopy.** 2d ed. New York, J Wiley, 1971.
.W5

CARDIOVASCULAR SYSTEM

- WG Burch, George E
140 **A primer of electrocardiography.** 6th ed. Phila-
.B8 delphia, Lea & Febiger, 1972.
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Should children be deprived of milk because of "lactose intolerance?"

No, according to the Protein Advisory Group of the United Nations.

In a special report, the PAG stated "It would be highly inappropriate, on the basis of present evidence, to discourage programs to improve milk supplies and increase milk consumption among children because of fear of milk intolerance." The statement emphasizes that low lactase activity and results obtained in tests with high lactose loads are not adequate indications of milk intolerance.

The statement also affirms the advisability of using milk as an excellent source of protein in child feeding programs.

Dairy Council is sponsoring further research on lactose intolerance. This is just another of the many areas of interest of Dairy Council, in the pursuit of better health for everyone through sound nutrition practices.

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—George Sarton, from "The History of Medicine Versus the History of Art"

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion

Results of a questionnaire to 7,000 physicians:

62.9%

Believe combination drug products are useful.

13.8%

Do not believe combination drug products are useful.

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription — which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in use for a number of years that have an apparently satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I'm thinking particularly of penicillin-streptomycin combinations that patients — especially surgical patients — were given in injection. This made less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosage errors. To take such preparation off the market doesn't seem to be good medicine, unless actual usage showed a great deal of harm from the injection (rather than the preparation) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it can avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence and in making the ultimate decision.

Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is certain that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be described separately. To avoid the appearance of redundancy, the "expert" decries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the worst of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the usual dose being 650 mg. The other semantic ploy often called into play is to describe a combination product as rational or irrational. Take antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

What is your opinion, doctor?

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Clinical Data:

Patient: 47-year-old male.

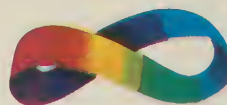
Diagnosis: Severe pyoderma, left hand.

Culture: *Staphylococcus aureus*, coagulase positive and sensitive to MINOCIN.

Temperature: 102° F

Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat*, 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.

Concomitant therapy: None.†



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Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has also been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug.

Pregnancy: In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. **Newborns, infants and children:** All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease

in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reaction: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. **Skin:** maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). **Renal toxicity:** rise in BUN, dose-related (see "Warnings"). **Hypersensitivity reactions:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. **Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. **CNS:** (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

*Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.
†Case Report, Clinical Investigation Department, Lederle Laboratories.



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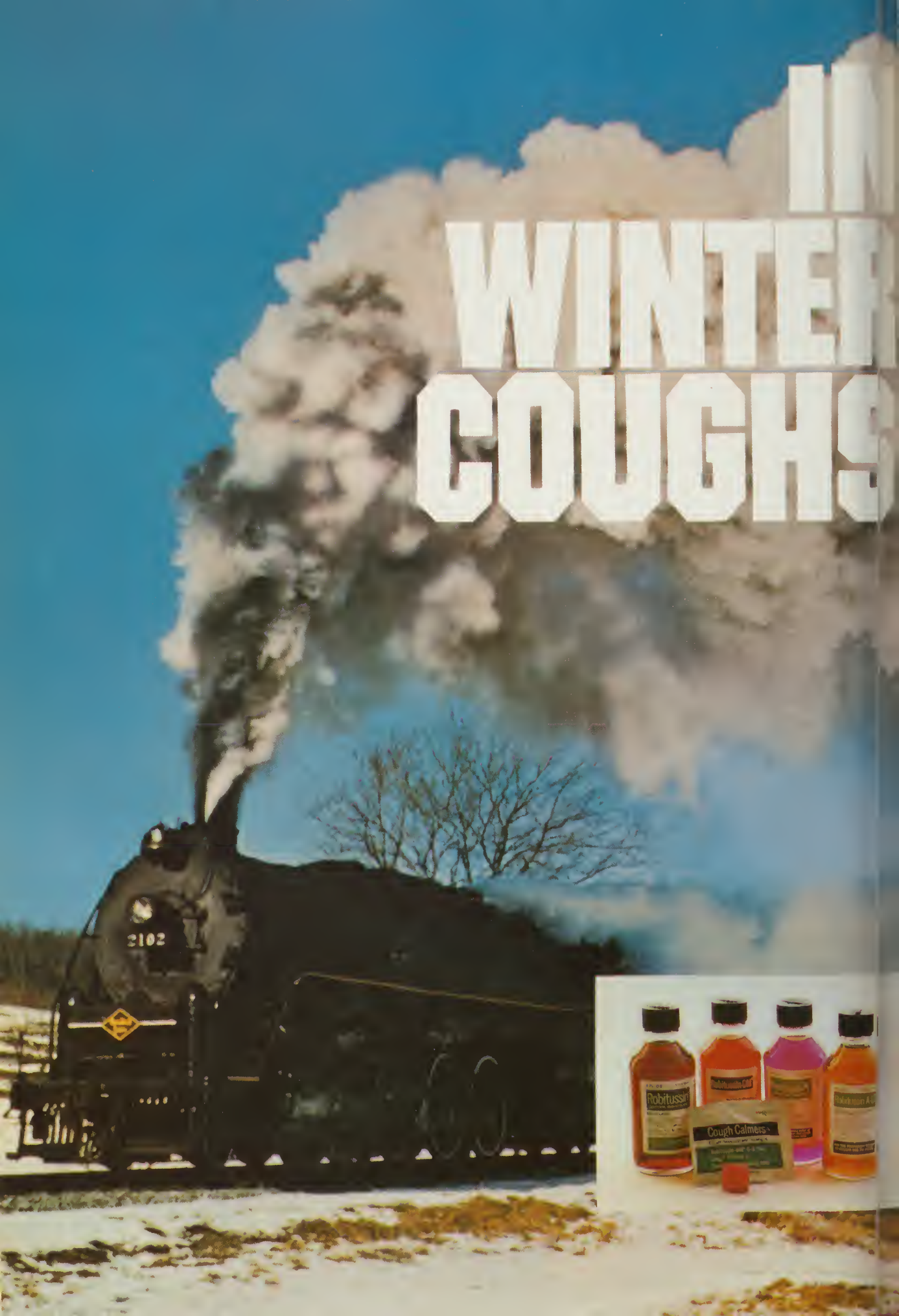
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Clears sinuses and nasal stuffiness as it relieves cough

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












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175th ANNUAL MEETING
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 APRIL 25, 26, 27, 1973
 BALTIMORE CIVIC CENTER

SCIENTIFIC EXHIBITS

Scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians and medical institutions who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held at the Baltimore Civic Center on

APRIL 25, 26, 27, 1973.

Ample space is available, however, it is suggested that applications be submitted as soon as possible.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
 Medical and Chirurgical Faculty
 1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit:
2. Please attach a 50-100 word description of the exhibit:
3. Give amount of space required, depth, width, and height:
 If exhibit has side panels, are depth and width included above?
 If not, what additional space is required?
4. Electrical or other requirements:
5. Has exhibit been shown at other medical meetings?
6. Name and title of exhibitor:
7. Name of institution cooperating in the exhibit:
8. Address of exhibitor:

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 500 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS,

DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.

5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

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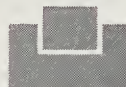
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emergency medical services



Development of Community Emergency Medical Services Councils

PAUL V JOLIET MD
Health Officer
Washington County Health Department
Hagerstown, Md

Information and reprint requests to Dr Joliet at PO Box 20667, Hagerstown Md 21740.

Too many people assume today that high quality emergency care is generally available. There is a general belief that *surely* some arm of government has acted to insure that it is. Sleek, shiny ambulances with authoritative flashing lights and wailing sirens manned by white-coated attendants give credence to such belief.

The facts are quite to the contrary. Quality and ready availability of emergency care services vary widely from one locality to another, but in most localities care is not so readily available and in many the quality of the care is likely to be primitive. Unbelievably, in some communities no pretense of any kind is made that any kind of first aid or personal care is given at all. In such places, ambulances are considered to be solely a means of transporting the victim from one place to another.

Yet injuries and sudden acute illnesses are a fact of life throughout the world and the victims need skilled emergency care. In most instances the scene of the accident is far from a hospital. It is seldom that a physician happens to be present when an emergency occurs and individuals are struggling for life. Natural disasters such as windstorms, floods, and earthquakes occur from time to time which may cause many injuries and deaths. Injuries and deaths are inevitable when autos crash, buses crash, aircraft fall, crowded grandstands collapse, or public places burn.

Sometimes an illness or injury can be so severe that only skilled administration of first aid within a few minutes can save life. One critical situation that occurs everywhere develops when an

individual cannot swallow a portion of food lodged in his throat. There is no more than three to five minutes to live if air cannot reach the lungs, so someone on the spot, trained in first aid may be the only hope.

The tragic frequency with which serious injuries occur in automobile crashes seems to have anesthetized — perhaps hypnotized would be a better word — the public into a feeling of helpless frustrations and acceptance. Such feelings in themselves are in large measure responsible for the tardy and frequently inadequate steps (if any are taken at all) either to prevent the occurrences themselves or to provide prompt and adequate emergency services — including medical services — to those who desperately require care. Consideration of the possibility that either a natural or man-made disaster can occur anywhere at any time seems repugnant and the usual reaction to the feeling is that it can't or probably won't happen here, or "to me."

National care-oriented organizations and groups, including the American College of Surgeons and other medical specialty boards, the American Medical Association Commission on Emergency Medical Services, the Red Cross, the US Public Health Service, Division of Medical Science, NAS-NRC, the US Department of Transportation, and the American Hospital Association, as well as many other care-oriented organizations, have been stimulating the improvement of emergency medical services.

Concurrently, safety and other groups such as the National Safety Council, fire, police, ambulance associations, rescue squads, Civil Defense organizations, communications organizations, etc,

and concerned community groups have been increasingly emphasizing the fact that if high quality care is *ever* needed, it is surely needed quickly when individuals suddenly become ill, or are severely injured.

Availability of emergency services too often determines the life or death of an accident victim.

Julian A Waller first pointed out that persons injured in rural counties were four times as likely to die of their injuries as those injured in urban counties. The nature of the injuries was about the same for rural and urban accidents. Persons dying in rural accidents more frequently died at the accident scene, died sooner after injury, and of less severe injuries.¹ Since then, other investigators in other sections of the country verified this observation. While it can *generally* be assumed that victims fare somewhat better in metropolitan areas than in rural counties, some investigators have shown marked differences within selected metropolitan areas.

The latter circumstances may be related to ambulance systems of varying quality and emergency rooms which may provide emergency medical care that ranges from bad to superlative. According to Dr Barry King, the quality of a community emergency medical care system depends upon decisions of the *local* authorities. These are based upon estimates of benefit to the sick and upon the cost of development and operation, and such estimates are quite variable.² The National Research Council summarized current practices and deficiencies at various levels of emergency care. Some salient factors included the following:

1) The general public is insensitive to the magnitude of the problem of accidental death and injury.

2) Millions lack instruction in basic first aid.

3) Few are adequately trained in the advanced techniques of cardiopulmonary resuscitation, childbirth, or other lifesaving measures, yet every ambulance and rescue squad attendant, policeman, fire-fighter, paramedical worker, and worker in high-risk industry should be trained.

4) Local political authorities have neglected their responsibility to provide optimal emergency medical services.

5) Research on trauma has not been supported or identified at the National Institutes of Health on a level consistent with its importance as the fourth leading cause of death and the primary cause of disability.

6) Potentials of the US Public Health Service programs in accident prevention and emergency medical services have not been fully exploited.

7) Data are lacking on which to determine the number of individuals whose lives are lost or injuries are compounded by misguided attempts at rescue or first aid, absence of physicians at the scene of injury, unsuitable ambulances with inadequate equipment and untrained attendants, lack of traffic control, or the lack of voice communication facilities.

8) Helicopter ambulances have not been adapted to civilian peace-time needs.

9) Emergency departments of hospitals are overcrowded, some are archaic, and there are no systematic surveys on which to base requirements for space, equipment, or staffing for present, let alone future, needs.

10) Fundamental research in shock and trauma is inadequately supported.

11) Medical and health-related organizations have failed to join forces to apply knowledge already available to advance the treatment of trauma, or to educate the public and inform the Congress.³

Accepting that injuries and serious illness occur frequently and that in most areas the emergency care services available are very poor, what can communities do to effectively upgrade those services where necessary? Since 1965, the AMA Commission on Emergency Medical Services has led a national effort to upgrade emergency medical care and reduce the number of accidental deaths. I E Hendryson MD, chairman of that Commission, believes that *concerted* community-wide action is essential to adequate emergency service.

Oscar P Hampton Jr MD, in the September 1968 issue of the Bulletin, American College of Surgeons, Sept-Oct 1968, expressed the belief that, first of all, a missionary — who is at the same time a top-notch salesman — must convince all concerned of the deficiency, the need and the solution. He feels that those concerned include the local government heads, the public health officer, the police and fire chiefs, the Civil Defense chief, local chapters of the National Safety Council and American Red Cross, ambulance services and hospitals served by them, and, last but not least, the medical profession. Dr Hampton suggests that the “missionary” do all in his power to obtain the support of those mentioned above — particularly the chiefs of services and administrators of local hospitals.

The local press and news media can be most useful in informing and arousing the general public. It is difficult to arouse the public about all the critical problems which confront society today. The AMA Commission suggests that a first

step might be to constitute a Community Council on Emergency Care Services. Motivation is one essential criteria for membership. Dissension within such councils, and jealousy between groups can and does impede and sometimes prevents progress.

The AMA Commission, after reviewing the experiences of the communities with organized emergency medical service councils, and after considering the opinions of experts from numerous groups, did arrive at a consensus, ie, that *concerned community-wide action is essential* to the provision of adequate emergency services. Therefore, the Commission produced a booklet entitled *Developing Emergency Medical Services — Guidelines for Community Councils*. It is available from the AMA, 535 N Dearborn St, Chicago, Ill 60610, at 20¢ per copy.

Because each community is a separate entity, the booklet offers guidelines, rather than hard-and-fast rules, which are useful to official and voluntary agencies and to all concerned in the development of improved services through a community council organized for that purpose. Because problems, resources, and personalities differ from one area to another — along with population density, geography, and relative services — problems and therefore solutions differ from one place to another. The guidelines have great potential to help in developing successful emergency services councils. When a basic system capable of meeting the smaller day-to-day emergencies is established and operating, a greater volume of casualties such as occur in disasters can then be handled by phasing more community resources into the system.

There are four basic components to a good emergency care system:

- 1) Broad-based training for on-the-spot aid.
- 2) A communications system which assures prompt response to needs.
- 3) Well-equipped emergency vehicles staffed by emergency medical technicians (ambulances), trained and equipped to provide all necessary life-support at the scene and during transportation.
- 4) High-quality emergency medical care facilities, staff, and equipment with the capability of direct communication with ambulances, Civil Defense, fire, and police.

Few communities have such a system. Some of the reasons why they do not have been implied. Failure of any component, fragmented effort, lack of coordination, and just plain jealousy, may be added. Obviously the first step toward im-

provement is to secure the cooperation and involvement of all appropriate community agencies and health facilities. When deep-seated and long-standing animosity or jealousy exists between essential elements of such a system, or when other impediments to funding or coordinating action exist, a community council may be the only organization that can succeed. Comprehensive community health planning agencies also have potential to help bring fragmented factions together for the common good.

There is nothing complex about either the formation or function of an Emergency Medical Services Council. From the beginning the council must include individuals representing all organizations required to contribute to such a system so all plan together. The council should assume the leadership role in the establishment of a fact-finding, planning, coordinating, and advisory subcommittees which can enlist the skills required in the diverse elements of the system.

The booklet, *Developing Emergency Medical Services — Guidelines for Community Councils*, is recommended to those who seek assistance in upgrading emergency care in individual localities. The truly amazing resistance to change that frequently is encountered, indicates the need for the measures outlined in the booklet if improvements are to be obtained in this vital segment of the medical care delivery system. All the necessary resources including funds, are not enough if the total community is not motivated into action.

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1. Waller JA, et al: Traffic deaths — a preliminary study of urban and rural fatalities in California. *Calif Med* 101, 4-272-276, Oct 1964.
2. King GB: Estimating community requirements for the emergency care of highway accident victims. *Am Public Health*, 48:8, 1422-1430, Aug 1968.
3. Div of Medical Sciences, National Academy of Sciences, National Research Council: *Accidental death and disability: the neglected disease of modern society*, fifth printing, Jan 1970, Washington.



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Premarital Health Testing

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For the convenience of Maryland citizens who wish to marry in the District of Columbia or one of the 44 states requiring premarital syphilis testing, the Central Laboratory of the Maryland State Department of Health and Mental Hygiene, located at 16 E 23rd St, Baltimore, Md 21218, will perform all tests and issue the appropriate certifications for the state in question.

Each of the 44 states and the District of Columbia issues its pertinent regulations, its lists of approved tests and approved laboratories, and its individual certification forms. Further, all of these states approve syphilis tests performed by the central public health laboratory of every other state.

The simplest procedure, therefore, for Marylanders desiring marriage in those states is for the physician to send a blood specimen to the State Central Laboratory with a request for the serologic test for syphilis, specifying clearly "For marriage in (state)". Other than Maryland, the states not requiring tests are Minnesota, Nevada, South Carolina, Washington, and (effective Oct 1, 1972) Maine.

There is more, however, to the story. Variations among the states and the changes in the development of new technologies are tending to multiply the types of health testing required in various states for premarital detection of various health conditions.

New laws and regulations are being announced so frequently that it is difficult to keep current with the individual requirements of every state. For instance, Colorado and Connecticut have recently required certification (for females) of an immunity test for rubella; Indiana has required (when the physician deems it necessary) an electrophoresis or other approved test to

determine if the marital partners are carriers of sickle cell anemia. It appears likely that other states may initiate individual laws for specific testing requirements.

Maryland's Central Public Health Laboratory has the capability of performing any of the tests that might reasonably be required premaritally by any state.

Under these circumstances, it is recommended that Maryland citizens intending to be married in another state seek early information from that state as to 1) health tests that are required, 2) laboratories or signatures that are accepted for the required tests, and 3) lead time. (Some states require testing within 15 days, most within 30 days before marriage.)

A comment seems warranted on the basis of Maryland's experience in the year ending June 30, 1972. During that year, 1147 persons were premaritally tested for syphilis on the basis of legal requirements for marriage in another state. Although a few cases of old, treated syphilis were disclosed, not one significant case of syphilis was found.

In the same year, 42 citizens of Maryland were tested for syphilis because of clinical indications (or because of other reasons). Of these, one active case of syphilis was detected. This represented 0.42% of the Maryland "premarital" specimens, compared with 8.46% positives of all specimens examined at the State Laboratory.

It is, therefore, considered far more useful that premarital laboratory testing for syphilis or other significant health conditions be performed on the basis of clinical indications than on the basis of legal requirements. These laws may often be imposed for reasons apparently directed toward public health, but they are possibly more likely introduced and passed for reasons of emotional or political appeal. Highest cost effectiveness in health programs, it is proposed, can best be attained by medical guidance rather than legislative mandate of the programs.

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AMONG THE SPEAKERS

at the

175th ANNUAL MEETING

Medical and Chirurgical Faculty, Baltimore Civic Center

Wednesday, Thursday, Friday April, 25, 26, 27, 1973

Bentley P Colcock MD, senior surgeon at the Lahey Clinic and associate professor of Clinical Surgery at the Boston University School of Medicine, will give the **I Ridgeway Trimble Fund Lecture** on Wednesday, April 25, 1973. His subject will be **DIVERTICULITUS**. Dr Colcock received his MD degree from the University of Pennsylvania and served both an internship and residency at the Philadelphia General Hospital, followed by a fellowship in surgery at the Lahey Clinic. During World War II, he received the Bronze Star while serving as a Lieutenant Colonel in the Medical Corps.

Dr Colcock is a past secretary of the Board of Governors of the American College of Surgeons; past president of the following organizations: Norfolk County Medical Society, Benjamin Waterhouse Medical History Society, Boston Surgical Society, New England Surgical Society; and past vice president of the American Surgical Association. He is also president of the Board of Trustees of the Boston Medical Library, a trustee of the Board of Governors of the Lahey Clinic Foundation, president-elect of the Massachusetts Medical Society, and chairman of the Board of Governors of the American College of Surgeons.

This presentation by Dr Colcock will be part of a full afternoon session cosponsored by the Maryland Chapter of the American College of Surgeons. Other physicians participating in this session will be Robert J Coffey MD, professor of surgery at the Georgetown University Hospital, who will speak on **NEOPLASTIC DISEASES OF THE COLON**; and Doctors Arthur E Cocco, John N Diaconis, and J C Handelsman, all of Baltimore.

The **Hundley Memorial Lecture in Gynecology** will be given on Thursday morning, April 26, 1973 by **Mary S Calderone MD**, executive director of SIECUS (Sex Information and Education Council of the US). Her discussion will be titled **SEXUALITY AND THE PRACTICE OF**



Dr Colcock



Dr Calderone

MEDICINE. To quote Dr Calderone: "It has been amply shown that the obstetrician-gynecologist is right at the cutting edge of the whole question of human sexuality."

Dr Calderone is also the cofounder of SIECUS and former medical director of Planned Parenthood Federation of America. She is a graduate of Vassar College, University of Rochester Medical School, and Columbia University School of Public Health. Honorary doctorate degrees have been bestowed on Dr Calderone in Laws, Humane Letters, Science, and Medical Science. Among the honors, too numerous to mention individually, that she has received are the Woman of Conscience Award, National Council of Women; 1966 Personality-of-the-Year, Collier's 1967 Year Book; Annual Award for Distinguished Service to Humanity, Women's Auxiliary, Albert Einstein Medical Center; and the Ladies' Home Journal, America's 75 Most Important Women, 1971. Dr Calderone is the author of numerous articles and books.

Married to Frank A Calderone MD, former Deputy Commissioner of Health of the City of New York and former Director of Health Services of the United Nations Secretariat, Dr Calderone has three daughters and is the daughter of Edward J Steichen, the photographer who created the **FAMILY OF MAN**.

GET THE FACTS AND BACKGROUND
VISIT THE EXHIBITS

**MEDICAL AND CHIRURGICAL FACULTY
OF MARYLAND
175th ANNUAL MEETING**

APRIL 25, 26, 27, 1973
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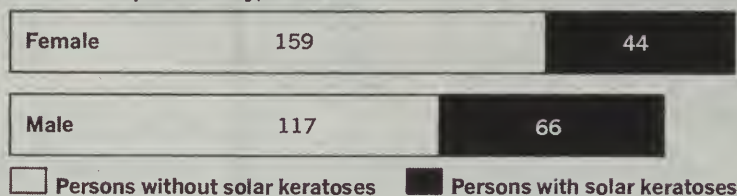
What it means to live and work in Tipton County, Tennessee

**Persons who are white and
over 40 have one chance in four
of having solar keratoses...
which may be premalignant**

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

**Prevalence of solar keratoses in white persons
over 40 in Tipton County, Tennessee**



*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

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Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

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Cosmetic results are highly favorable. Incidence of scarring is low—important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

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Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

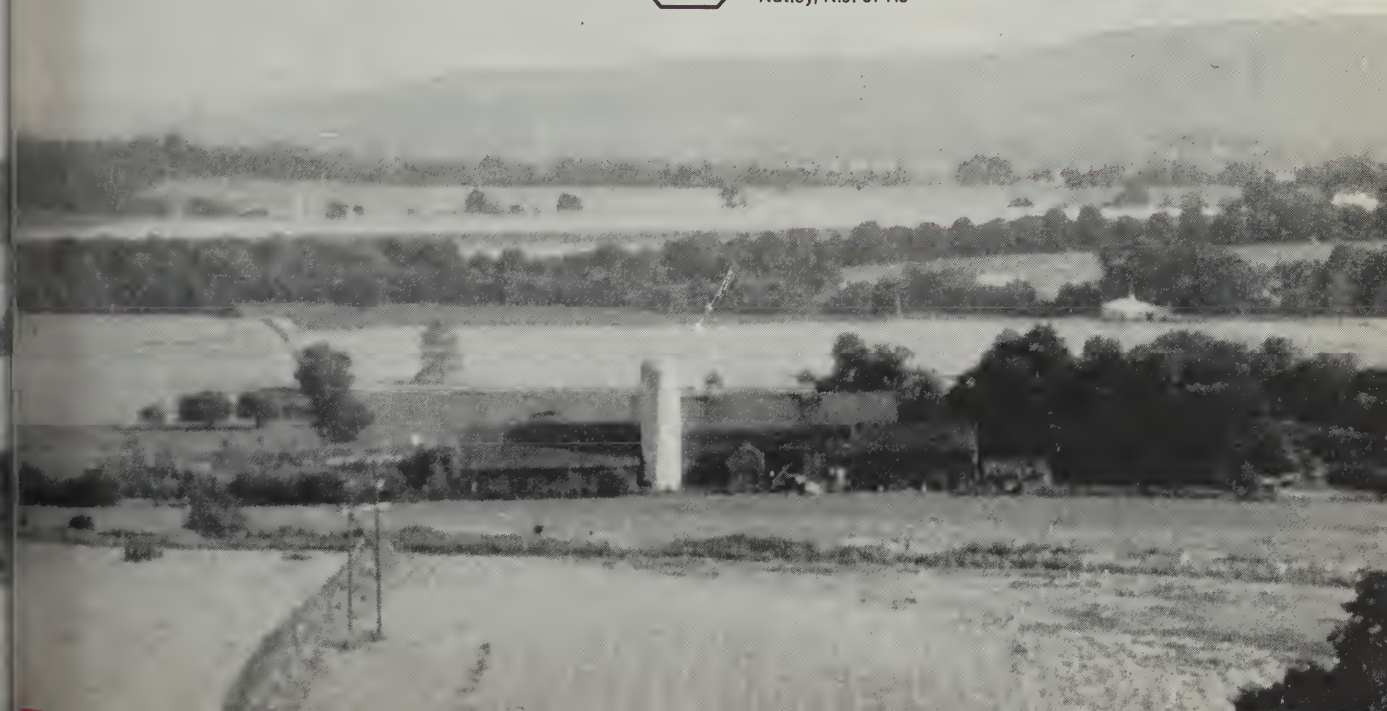
How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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2) Traveling by public transportation, be sure luggage is securely labeled outside, with identification inside. Keep your eye on unchecked luggage. Use only authorized porters.

3) Traveling by car, don't park on dimly lighted streets after dark. Don't pick up hitchhikers. Preplan your route so you won't arrive late at night and will avoid high-crime areas. Leave only your ignition key if you park in a lot or garage that insists you leave a key. If endangered in your car, lock the doors and blow your horn staccato-style.

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Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water

thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced ejaculator volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the drug should be stopped.

Adverse Reactions: Acne. Decreased ejaculator volume. Gynecomastia. Edema. Hypersensitivity reactions including skin manifestations and anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.

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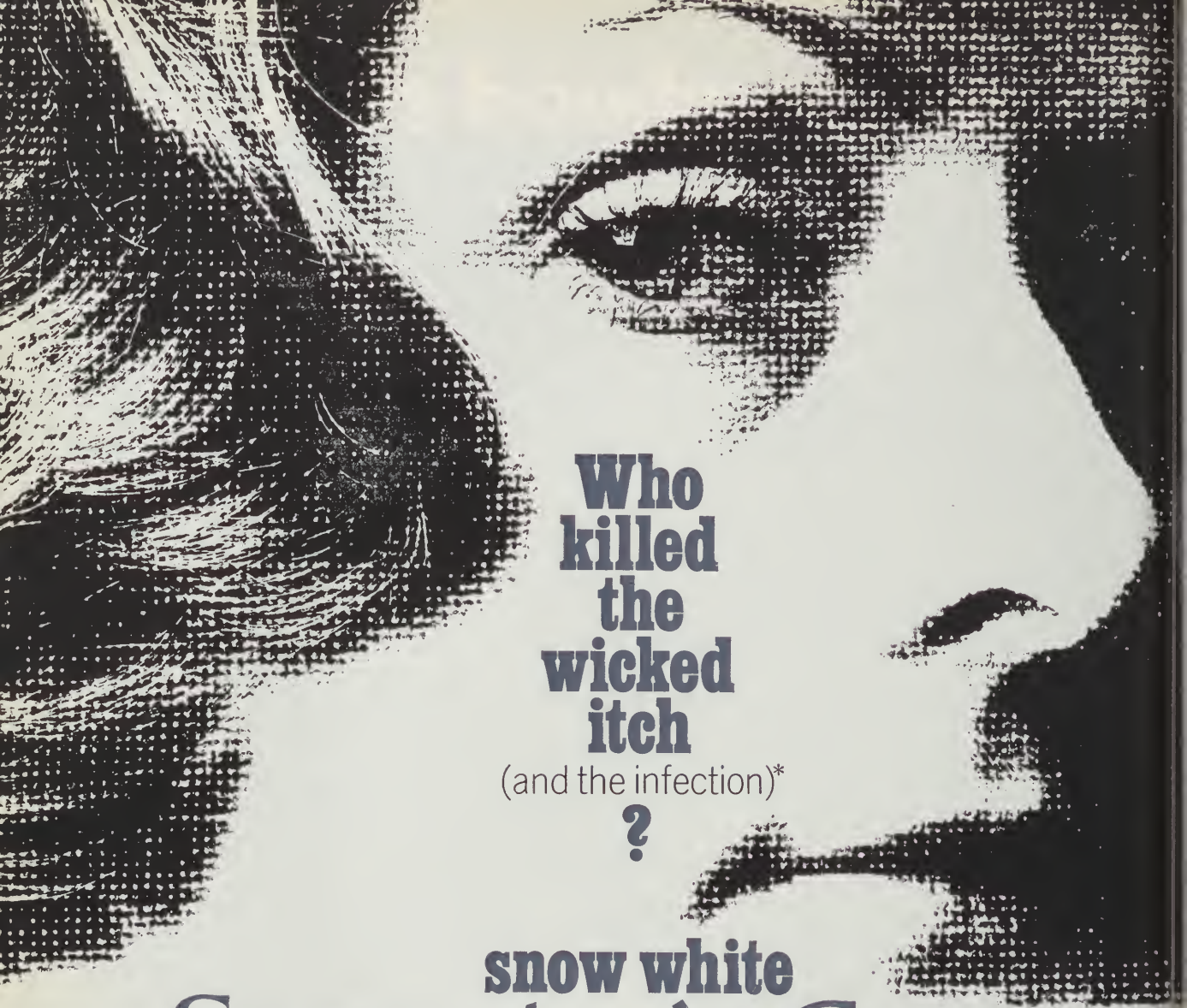
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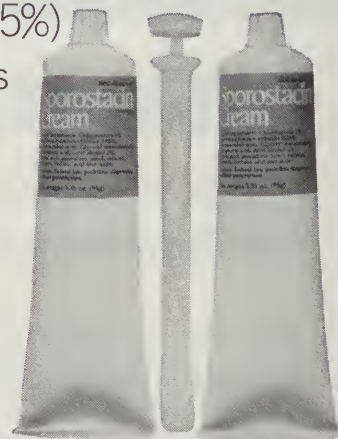
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Indication: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:

“Probably” effective: For the treatment of vulvovaginal candidiasis.

Final classification of the less-than-effective indications requires further investigation.

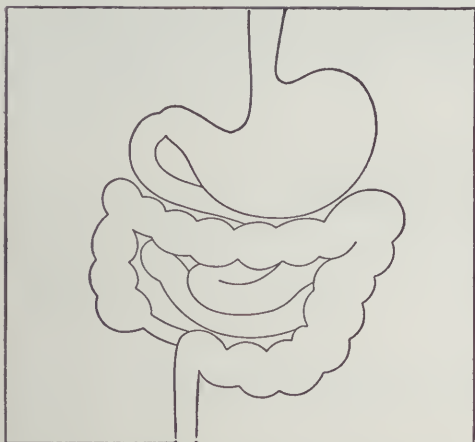
Contraindications: None known. **Precautions:** Cases of sensitization and irritation have been reported. When noted the drug should be discontinued. **Dosage:** One applicatorful intravaginally twice daily for a period of 14 days. Course of therapy may be repeated if necessary.

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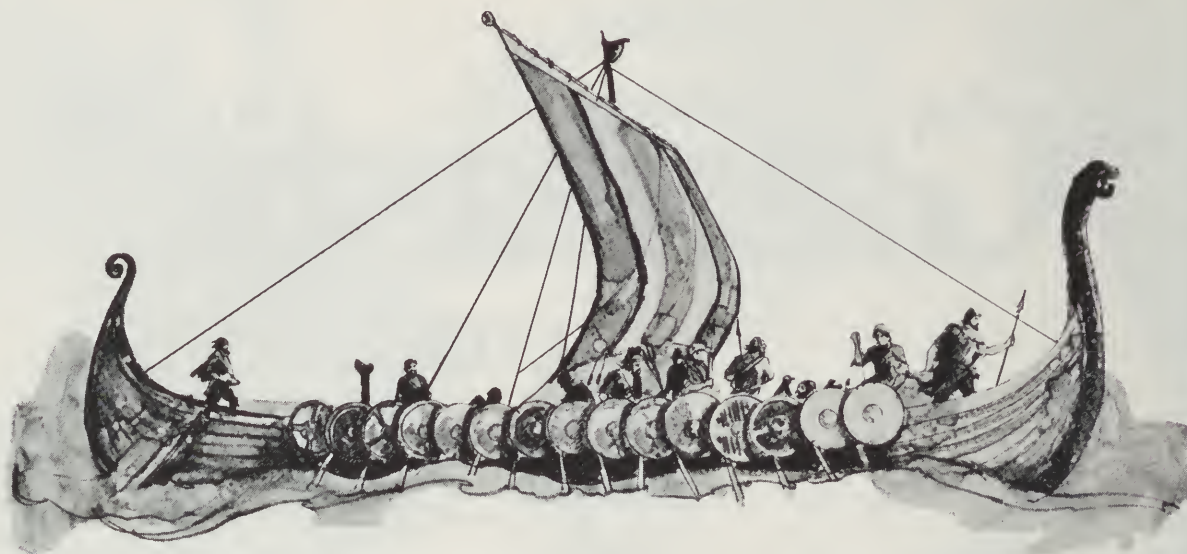
can do more

Contraindications: Anticholinergics should not be used in patients with glaucoma, known prostatic hypertrophy, or pyloric obstruction. Urinary retention may indicate the presence of prostatic hypertrophy. If it occurs, the dose should be reduced or the drug withdrawn. Also contraindicated in patients with known hypersensitivity to one of the components.

Side Effects: Dryness of the mouth, blurred vision, dysuria, skin rash, constipation or drowsiness may occur.

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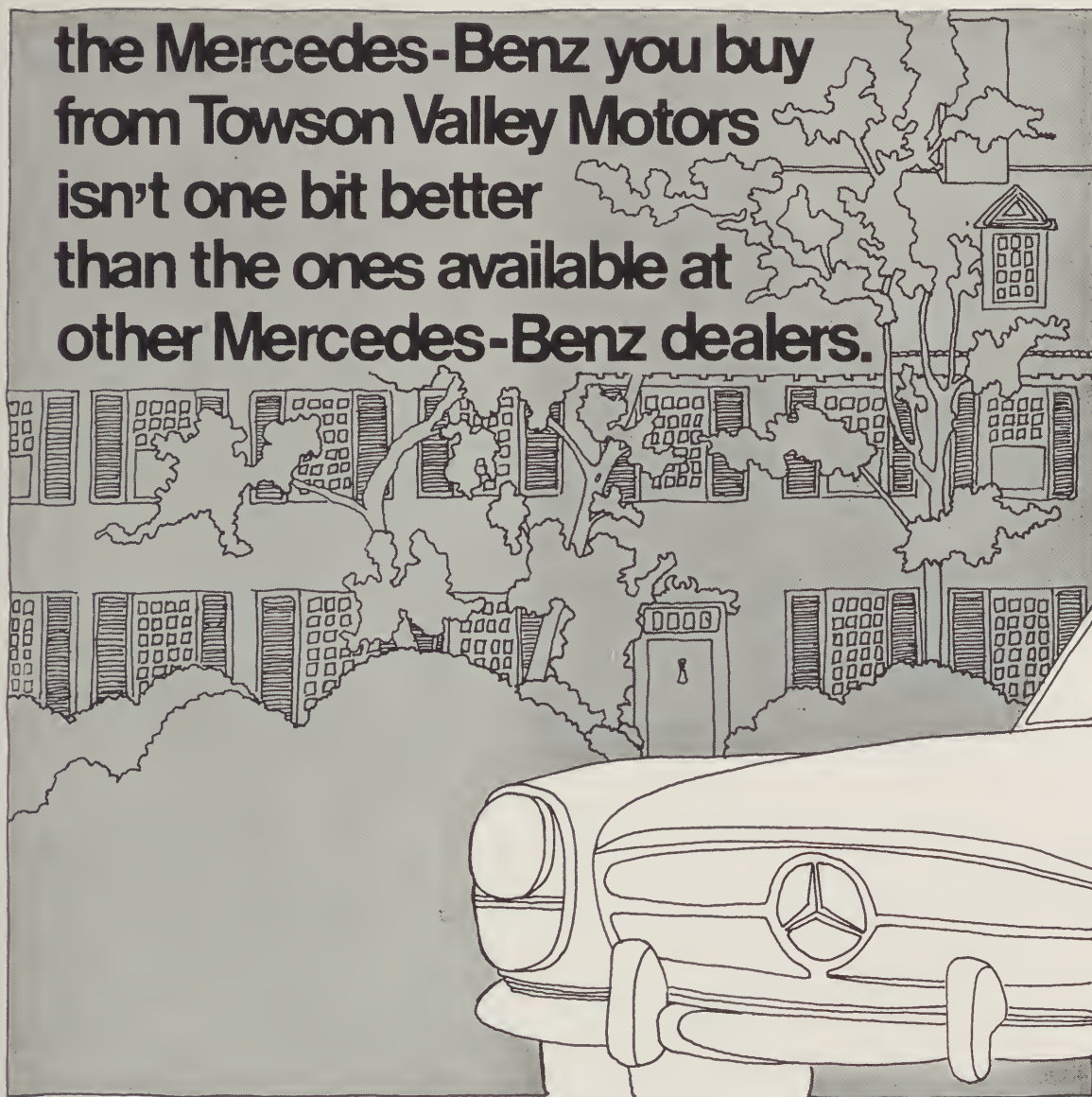
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debili-

tated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the

elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased or decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

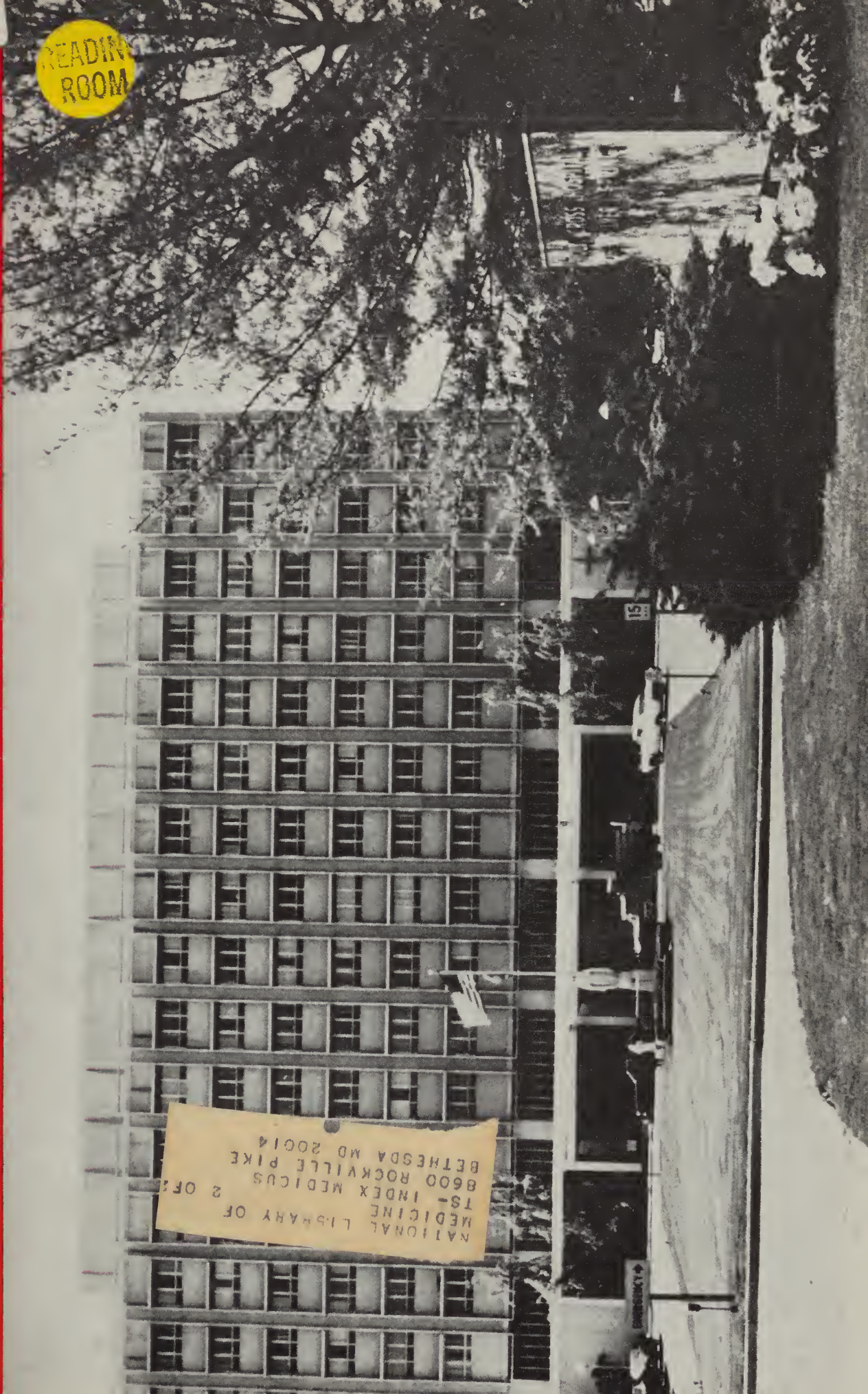
Supplied: Librium® capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



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Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

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Tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasias); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

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MARCH 1973

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Elmer George Linhardt MD, the physician being featured this month in the Council series, is probably best known as the Executive Secretary of the Maryland State Board of Medical Examiners—at least to all doctors seeking licensure in Maryland.

He became a member of the Med-Chi Faculty Council as Councilor for the Southern District at the conclusion of the 1972 Annual Meeting.

The Annapolis native has offices at 3 Chesapeake Avenue in Annapolis and in the Faculty building at 1211 Cathedral Street (Board of Medical Examiners).

He is on the active surgical staffs at the Anne Arundel General Hospital in Annapolis and the North Arundel Hospital in Glen Burnie; he also serves as Deputy Medical Examiner for Anne Arundel County.

His birth date was Nov 17, 1914. He and his wife, Elizabeth, AMAERF Chairman for the Woman's Auxiliary, have two children and reside at 3 Chesapeake Ave, Annapolis, Md.

After completing his premed at St John's College in Annapolis in 1933, he entered the University of Maryland School of Medicine and received his MD in 1937.

This was followed by a period of internship at Baltimore's St Agnes Hospital and 1942-1946 service with the US Army Air Force.

Dr Linhardt serves as Assistant Professor, Department of Anatomy, University of

Maryland School of Medicine.

In addition to AMA, Med-Chi, and Anne Arundel County Medical Society memberships, Dr Linhardt's "Who's Who" list of memberships includes the following:

American Society of Abdominal Surgeons

AMA Section on General Surgery

Commission on Medical Discipline, State of Maryland

FLEX Test Examination Committee

Medical Advisory Board, Department of Motor Vehicles

Professional Practice Committee, Maryland Hospital Association

Committee on Continuing Medical Education (Med-Chi)

Southern Society of Anatomists

New York Academy of Sciences

Dr Linhardt is a Fellow in the International College of Surgeons. He is also a Fellow and member of the Scientific Council of the International Academy of Angiology.

He serves as Maryland Regent for the International College of Surgeons, and also as Surgical Consultant to the Social Security Administration.

He is Consultant/Surgeon for the School Sisters of Notre Dame, St Mary's Convent, Annapolis.

Moving to the area of civic



Dr Linhardt

and social clubs, we find that Dr Linhardt is a resident member of the Annapolis Yacht Club, the Annapolitan Club of Annapolis, and the Annapolis Power Squadron.

He is a member of the University of Maryland Medical Alumni Association, and of the St John's College Alumni Association.

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Doctors in the News

Three Maryland physicians and two Baltimore medical centers have been granted American Cancer Society support for special training in treating cancer patients, it has been announced by **Elmer C H Schmidt MD**, Easton, President, ACS Maryland Division.

Clinical fellowships valued at \$4800 each have been granted to **Bruce H Thompson MD** and **Gerald Suffrin MD**, both of the Johns Hopkins School of Medicine, and **Harvey J Bellin MD**, of Sinai Hospital of Baltimore.

In addition, Dr Schmidt reported three fellowships were awarded to divisions of the Johns Hopkins University School of Medicine and the Sinai Hospital of Baltimore, allowing these institutions to select and train fellows in cancer work.

Among the scientific exhibit award winners at the recent 31st Annual Meeting of the American Academy of Dermatology was **Raymond C V Robinson MD**, Greater Baltimore Medical Center, Towson. Dr Robinson received the Bronze Award for his presentation on "Syphilis and the Minor Venereal Diseases."

James Frenkil MD, director of a privately-owned industrial medical clinic in Baltimore, has been selected as "Boss of the Year" by the Monumental Chapter of the National Secretaries Association. He will be so honored

at the chapter's annual executive night in April.

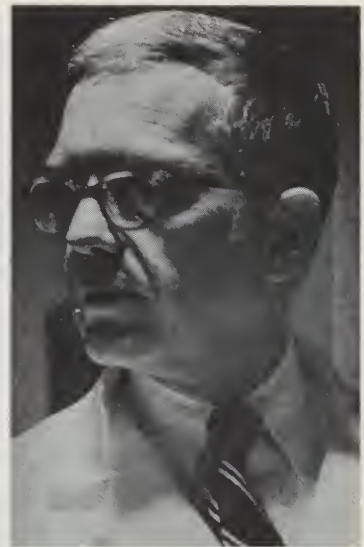
During the Fifth Annual Taylor Manor Hospital Psychiatric Symposium in Ellicott City on April 7, the 1973 Taylor Manor Hospital Psychiatric Award will be made to **Jacques S Gottlieb MD**, a famed researcher in schizophrenia from Detroit.

Frank J Ayd Jr MD, a Baltimore psychiatrist and previous recipient of the Award, is Symposium Director. "Schizophrenia Around the World" is the symposium theme.

Dr Gottlieb is Professor and Chairman of the Department of Psychiatry, Wayne State University School of Medicine and Director of the Lafayette Clinic.

L P Chow MD, Baltimore, has been granted an 18-month, \$33,834 research grant from the Ford and Rockefeller Foundations to study the impact of reform of abortion laws in Taiwan. Dr Chow is connected with Population Dynamics and Public Health at Johns Hopkins.

The American Association of Psychiatric Services for Children has honored **Burton G Schonfeld MD** with the Freda R London Trainee Award for his project, "The Washington Free Clinic—An Innovative Approach to Delivery of Free Comprehensive Health Care Services to Youth in Distress." Dr Schonfeld received his MD from the University of Maryland in 1968 and is currently in training in



Dr Ross

his fourth year in Child Psychiatry at Hillcrest Children's Center in Washington, DC.

Richard S Ross MD, Director of the Cardiovascular Division of the Department of Medicine, Johns Hopkins University School of Medicine, and Director of the Myocardial Infarction Research Unit, Johns Hopkins Hospital, has been selected to serve as President-elect of the American Heart Association for the year 1972-1973. Among the many offices he has held is that of President of the Heart Association of Maryland in 1967.

McRae Whitaker Williams MD has been named Chief, Department of Ambulatory and Community Medicine, Union Memorial Hospital, Baltimore.

Emmanuel S Francois MD, formerly Senior Resident in General Surgery at New York's Harlem Hospital, has been appointed full-time Associate in the Department of Surgery, Provident Hospital, Baltimore.

Samuel L Fox MD, Baltimore, has been appointed Medical Director of the Maryland Drug Abuse Administration.

In announcing the appointment, **Neil Solomon MD**, Maryland Secretary of Health and Mental Hygiene, said, "Dr Fox has a rich background in both medicine and pharmacology and is well suited to make a valuable contribution in providing professional direction in the drug abuse area."

A 1934 Pharmacy grad from the University of Maryland, Dr Fox received his MD there in 1938, and is now in the private practice of medicine.

Jonas R Rappeport MD, Chief Medical Officer of the Medical Service of the Supreme Bench of Baltimore, has been appointed Adjunct Professor of Law of the University of Maryland Law School.

G Lennard Gold MD, who practices Internal Medicine in Silver Spring, has been appointed to the Chemotherapy Advisory Committee for the Cancer Treatment Division of the National Cancer Institute. The appointment runs until 1976.

The Baltimore City Medical Society has elected **Katherine**

H Borkovich MD President. She is the first woman to hold the office since the Society was founded in 1788, and is an associate professor of medicine at Johns Hopkins.

Other officers who will also serve during 1973 include:

John B De Hoff MD, President-elect

Douglas G Carroll MD, Vice President

Philip Whittlesey MD, Secretary

Richard L London MD, Treasurer

Elected to two-year terms on the Board of Directors were **Rafael Garcia-Bunuel MD**, **Hiroshi Nakazawa MD**, and **Nathan E Needle MD**.



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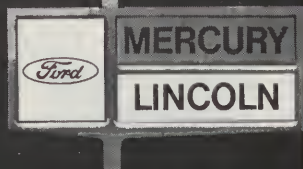
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2:00 pm to 4:30 pm—Convulsive Disorders
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Medical Legal Responsibilities

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Ad Hoc Planning Committee for Symposium

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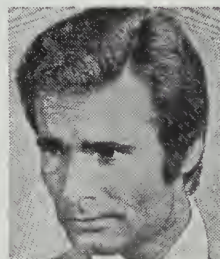
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John Galsworthy

FREDERICK J BALSAM MD
Editor

rehabilitation medicine

THE ROLE OF SPORTS IN REHABILITATION OF THE HANDICAPPED Part 1B: Historical

NORMAN B ROSEN MD

Dr Rosen is Assistant Physician-in-Chief and Director of Rehabilitation Therapies for the Maryland Rehabilitation Center, 2301 Argonne Dr, Baltimore, Md 21218. He is also Consultant in Rehabilitation Medicine at Baltimore's North Charles General Hospital and Kernan Hospital for Crippled Children. He is also Instructor in Rehabilitation Medicine at the University of Maryland Medical School.

Information and reprint requests to Dr Rosen.

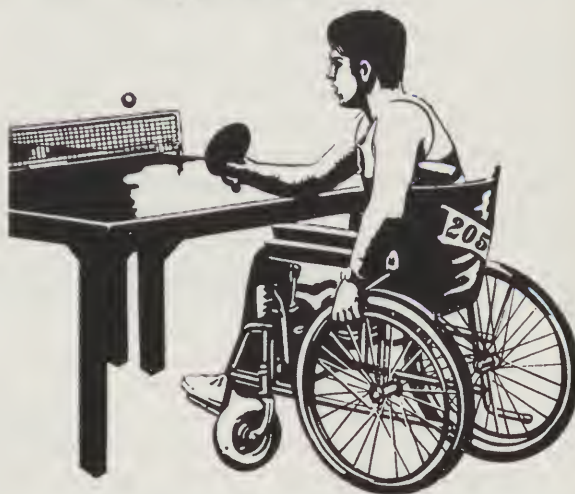
Flying Wheels

In 1946, an effort was made to publicize the abilities of the handicapped. It was thereby hoped that some of the barriers, physical and emotional, preventing the handicapped individual from functioning independently in society would be removed. It was reasoned that if the public at large could see the disabled patient perform in activities requiring strength, skill, and determination, there would be made available increased opportunities for the handicapped to fit into the mainstream of day-to-day living. By extension, increased opportunities would be provided for the handicapped to become self-reliant, responsible, and respectable income-producing members of society.

In order to achieve this goal, one of the first touring wheelchair basketball teams, from Van Nuys, Calif, called the *Flying Wheels*, was formed.

And the *Flying Wheels* did, indeed, generate a great deal of enthusiasm for wheelchair sports of all sorts; perhaps, more importantly, it achieved the goal of publicizing that the handicapped were potential members of the work force and of society and that they had the determination, self-confidence, and the ability to perform tasks that society had previously assumed were beyond their capabilities.

In 1947 and 1948, new wheelchair basketball teams appeared all over the United States: *Pioneers of Kansas City*, *Brooklyn Whirlaways*,



The paraplegic athlete, symbol of the 21st International Stoke Mandeville Games in Heidelberg, Germany.

Minneapolis Gophers, *Gizz Kids* of the University of Illinois, *St Louis Rams*, *Bulova Watchmakers* of Woodside, NY and other teams were just a few of the new teams that developed. Today, there are over 50 different teams competing against one another in the United States. There is an association of wheelchair basketball players called the National Wheelchair Basketball Association. This organization was formed in the late 1940s by the Director of Student Rehabilitation at the University of Illinois, Professor Timothy Nugent.

Stoke Mandeville Games

In the meantime, in England, a similar evolutionary process was occurring, but along slightly different lines.

In 1948, corresponding with the opening of the International Olympics in London, Dr Guttmann introduced the first organized wheelchair sports program in Europe at his Spinal Injuries Center at Stoke Mandeville. This program, started as an archery competition between 26 British paraplegics representing two different rehabilitation centers, subsequently evolved to

include other sports and eventually became known as the Stoke Mandeville Games. These games have been played yearly since their inception and have been expanded to include other wheelchair events such as English bowls (lawn bowling), table-tennis, shot-put, javelin-throwing, club-throw, basketball; and, by 1960, fencing, snooker, swimming, and weightlifting.

The Games took on international proportions in 1952 when a team representing the Netherlands was invited to meet in competition with the British team. By that time, 130 competitors were participating in the various events.

Paralympics

By 1957 there were 360 competitors from 24 countries. In 1960 over 400 wheelchair-bound athletes traveled to Rome to compete in the International Stoke Mandeville Games. This was the first time that the Paralympics, as the games were also to be called, were played in the same country that was to host the International Olympics. This was done in an effort to further publicize the accomplishments of the disabled and to do so on a world-wide scale. Since 1960 (except for 1968), in addition to the yearly Games at Stoke Mandeville, the Games have been hosted by the same nation that has hosted the International Olympics. In 1964 the locale was Tokyo, and in 1972 the Games were played in Heidelberg, just several hundred kilometers northwest of the Munich Olympic site. In 1968, because of the feeling that the high altitude of Mexico City would be detrimental to many of the participants, the Games were held in Tel-Aviv. During these games, 730 competitors from 27 countries participated; in 1972, over 1,000 wheelchair athletes representing 43 different nations traveled to Heidelberg to participate in 14 different events for both men and women.

National Wheelchair Games

In anticipation of the entry of the United States into the Stoke Mandeville Games, the National Wheelchair Games were held for the first time in 1957 at Adelphi College under the combined auspices of the Paralyzed Veterans Association of America, Adelphi College (now Adelphi University) of New York, and the Joseph Bulova School of Watchmaking. This latter organization, a tuition-free school for the disabled, which, under direction of Benjamin Lipton, had been actively engaged in training the handicapped for productive employment, was one of the earliest sponsors of wheelchair athletics and wheelchair competition. Since 1957 these games have been held yearly in the United States at the Bulova Park in Long Island, NY. The United States National Wheelchair Games were patterned after the Stoke Mandeville Games

but introduced for the first time such events as the 60-, 100-, and 220-yard dash, the 220- and 400-yard relay, discus throw, and the wheelchair slalom. Subsequently, weightlifting was added.

Pan American Wheelchair Games

As news of the successes of wheelchair sporting events spread to more and more countries, and as medical and social advances allowed participation of more and more competitors, other formal competitions were also established. The first Pan American Wheelchair Games were held in 1967 at the site of the Pan American Games in Winnipeg, Canada and included teams from Argentina, Canada, Mexico, Trinidad, Tobago, and the United States. Subsequently, this event has been held every two years in nations of the Western Hemisphere. When the Second Pan American Wheelchair Games were held in Buenos Aires in December 1969, over 250 contestants from all parts of the Americas took part. The 1971 Games were held in Kingston, Jamaica; the next Games are scheduled for 1973.

As the competitive events grew both in numbers and in numbers of participants, all with varying degrees and types of disabilities, it became necessary to establish classifications based on the level of disability that any given participant demonstrated at the time of participation. Several systems have been set up to grade functional levels; and they, together with more detailed descriptions of the specific competitive events, will form the basis of Part II of this paper.

"The aim of the Stoke Mandeville Games is to unite paralyzed men and women from all parts of the world in an international sports movement, and your spirit of true sportsmanship today will give hope and inspiration to thousands of paralyzed people. No greater contribution can be made to society by the paralyzed than to help, through the medium of sport, to further friendship and understanding amongst nations."

This is the message of the Stoke Mandeville Games which, throughout the games, stands at the entrance to the sportsground as a reminder to all who enter. In the yearly competitions which have followed the 1948 inauguration, several thousand athletes have participated in these events which have also been known as the *Wheelchair Olympics*, the *Paralympics*, and the *World Games for the Disabled*. The message is clear and, indeed, is a tribute to those pioneers whose vision and dedication enabled a formerly hopeless and hapless group of the disabled to "stand tall" with self-confidence, self-reliance, and the respect of their more able-bodied colleagues.

To be continued

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Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water

thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced ejaculate volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the drug should be stopped.

Adverse Reactions: Acne. Decreased ejaculate volume. Gynecomastia. Edema. Hypersensitivity including skin manifestations and anaphylactic reactions. Priapism. Hypercalcemia (especially immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.

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MED 8-6-5 (P)



ROBERT E FARBER MD MPH
Commissioner

Baltimore City health department

ADVISORY COUNCIL FOR FAMILY PLANNING PROJECT

A 21-member Advisory Council for the City Health Department's Family Planning Project 722 has been formed to foster the growth of healthy two-way communications between the project and the community.

According to Mr Melvin Moore, administrative health officer, the Council will report to the commissioner of health of Baltimore City, the director of the City Health Department's Bureau of Maternal and Child Health, and the Family Planning Project. Members will participate in the planning for the project; help in the location, acquirement and development of sites for clinics; assist in recruiting staff; help evaluate the program; and assist in interpreting family planning services to the community.

Installed on March 29, the Council already has met to review and has approved the revised proposal for federal refunding for the Family Planning Project. The project is funded three quarters with federal funds and one quarter in city matching funds.

The Council comprises two boards—a Family Planning Project 722. The chairman is Mr community representatives, and a Medical Advisory Board with six physicians and one nurse-midwife. According to federal guidelines, a majority of the Council must be patient-community representatives. Members were named by the commissioner of health from recommendations by the director of the Bureau of Maternal and Infant Care Services and the directors of the Family Planning Project 722. The chairman is Mr. Lloyd McDonald, supervisor of coordination, Community School Division, Baltimore City Public Schools.

Family Planning clinics are in nine locations. Physicians who wish to refer patients to the

family planning clinics should tell them to call their nearest health district building. In the past year, 16,568 persons availed themselves of these services which are provided to any Baltimorean who requests help.

Cherry Hill Multipurpose Complex

The new Cherry Hill Multipurpose Complex located at 2490 Giles Road was dedicated Sunday, Oct 29, 1972.

This new structure, for which the ground was broken a year ago on the same date, was planned and brought to fulfillment by members of the Cherry Hill community with support from Mayor William Donald Schaefer and other city and state officials.

Uniquely, the new building houses both city and state agencies and makes their services available in greater depth to the residents. Now together at one location are City Health Department clinics, an office of the City Department of Social Services, and state-operated Inner City Community Mental Health and Drug Abuse centers.

The communities served by the new complex include Cherry Hill, Mt Winans, Westport, Lakeland, Brooklyn, Fairfield, Dorchester, Curtis Bay, Riverview, and Wagner's Point. For information call 354-0300.

Swafford to Special Home Services

Mr Orville A Swafford, formerly of the Bureau of Industrial Hygiene, has been promoted to Assistant Director in the City Health Department's Bureau of Special Home Services. Mr Swafford will be responsible for all bureau client services provided to elderly ill patients of Baltimore City who are in need of help.

A graduate of Morgan State College, Mr

Swafford received his early education in the public schools of Hamilton County, Tenn. After enrolling at Morehouse College in Atlanta in 1945, Mr Swafford was called into the service and spent three years in the Army in the Far East. Following his discharge he entered Morgan State where he earned a BS in Biology in 1953. In addition to his eight years' work as a sanitarian in air pollution control in the Bureau of Industrial Hygiene, Mr Swafford's work experience includes nine years in sales and public relations work in private industry.

In his new post Mr Swafford will work with health aides and volunteers providing assistance to Baltimore residents 60 years and older who need help. The service is available on request. Anyone may make a referral to the bureau by calling 752-2000, ext 2856. Following the call a home visit is made by a health aide to determine the services needed. Continuous home visiting may be provided by an assigned health aide who acts as a link between the clients served and the direct service agencies. Health aides also keep in touch with the family of the client, accompanying clients to hospitals and clinics, arrange for clients' transportation when needed, intercede as aggressive advocates in the clients' behalf, and generally do whatever is necessary to insure that needed services are provided. Presently about 9000 clients are being served by the bureau's 75 staff members.

Mr Swafford's office is located on the 14th floor of the American Building, 231 E Baltimore St, phone 752-2000, ext 2856. Physicians who may have elderly clients eligible for the bureau's services should call Mr Swafford.

The National Society for the Prevention of Blindness urges individual hunters to have their eyes checked each year before taking to the woods.

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executive director's newsletter

March 1973

MORE ON NATIONAL HEALTH INSURANCE

In an article appearing in the University of Rochester Alumni News, Richard N Rosett, a UR Economist, is quoted as saying that all plans (for health insurance now in Congress) violate fundamental insurance principles and ignore basic laws of economics.

In a further quote, he is reported as saying, "National health insurance would be prohibitive in cost, impossible to administer, and wouldn't significantly improve the quality of care."

A study recently completed for HEW by him indicates that those plans giving full, first-dollar coverage to every family could increase demand by as much as 250%, a figure substantially higher than preliminary government estimates.

He is also quoted as saying, "We will soon discover that it is cheaper to bear a significant part of our medical expenses and to give the health industry incentives to give us what we want at prices we are willing to pay."

TRIP TO SCANDINAVIA

A few seats still remain on the charter trip to Scandinavian countries, departing Baltimore on May 31, 1973.

Details may be obtained by contacting the Faculty office, or as outlined in the ad on page 36 of this issue of the Journal.

MEDLINE SYSTEM IN LIBRARY

By May 1 our MEDLINE terminal, connected on-line with the National Library of Medicine in Bethesda, should be operational in our library. The entire medical community in the state will be eligible for this literature-searching service without charge. Instructions and request forms will be available from the library as soon as the service is implemented.

AMA SURVEY

In late February every US physician received an AMA questionnaire concerning his professional activities. Information from the questionnaires will be used in the

publication of the 1973 edition of the AMA's American Medical Directory. The date will also be used in statistical studies of physician manpower.

PHASE 3
PRICE
SCHEDULE

Price schedules and signs are no longer required in physicians' offices or in health care institutions. Phase 3 regulations published in the Jan 12 Federal Register continued wage and price controls on the health services industry but revoked the Phase 2 regulations that had required physicians and institutions to keep available for public inspection a schedule showing charges for principal services and to post a sign giving the location of the schedule.

AMA
REBUTTAL

Copies of AMA's letter to NBC-TV protesting the inaccuracy and bias of the Dec 19 program What Price Health? and requesting equal time are available from American Medical News, AMA Headquarters.

REFERENCE
COMMITTEE
HEARING


Thursday, March 29, 1973, at 8:00 PM has been chosen as a tentative date for the Reference Committee meeting.

At this session, resolutions for consideration at the House of Delegates meeting on Friday, April 27, 1973 will be discussed. Individual members and other interested parties may attend and express their viewpoints on resolutions.

Deadline for introduction of resolutions, except through the Council or Faculty Committees, is Friday, March 3, 1973.

TBC
TREATMENTS

Physicians who are at present treating patients for TBC with Isoniazid may obtain a copy of current reports regarding liver disease among such recipients. Contact the Faculty office.


Executive Director

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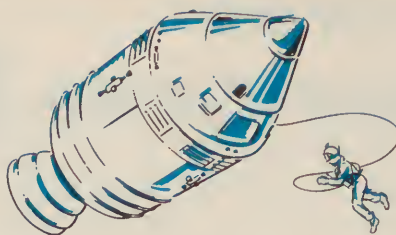
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**MEDICINE IN MARYLAND: 175th ANNIVERSARY
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WEDNESDAY, THURSDAY, FRIDAY, APRIL 25, 26, 27, 1973
BALTIMORE CIVIC CENTER**

Over 19 specialty and general presentations will be given during this 175th Annual Meeting of the Faculty.

MODERN TRENDS IN GERIATRIC MEDICINE will be the title of the **Jesse C Coggins Fund Lecture** given by **W Ferguson Anderson MD**, David Cargill Professor of Geriatric Medicine, University of Glasgow, Scotland.

ISCHEMIC HEART DISEASE will be the general title for a session of which **Richard S Ross MD**, Clayton Professor of Cardiovascular Disease, the Johns Hopkins University School of Medicine, will be the moderator. The participants will be

Bertram Pitt MD, EVOLVING CONCEPTS OF MYOCARDIAL ISCHEMIA —
A BACKGROUND FOR THERAPY

C Richard Conti MD, THE SYNDROME OF UNSTABLE ANGINA PECTORIS —
A THERAPEUTIC CHALLENGE

David T Kelly MD, and **Dean R Taylor MD**, MYOCARDIAL INFARCTION —
EVALUATION OF THERAPY IN 1973

A panel discussion will follow in which all of the above will participate plus **Leonard Scherlis MD**, Professor of Medicine and Head of the Department of Cardiology, the University of Maryland School of Medicine.

THE PROBLEMS OF POLYARTHRITIS, a panel discussion moderated by **Mary Betty Stevens MD**, Associate Professor of Medicine, the Johns Hopkins University School of Medicine, will have as participants **Werner F Barth MD**, **Harry F Klinefelter MD**, **Thomas M Zizic MD**, **Gaylord L Clark Jr MD**, and **Jack W Bowerman MD**.

CURRENT CONCEPTS IN THE THERAPY OF CONGESTIVE HEART FAILURE, a panel discussion moderated by **William J Kinnard Jr, PhD**, Dean of the School of Pharmacy, University of Maryland, will have as participants **Robert A Kerr, PharmD**, **John B Young, PharmD**, and **Anthony S Manoguerra, PharmD**.

DISEASES OF THE COLON will be the title of a panel discussion on which **Bentley P Colcock MD**, Chairman of the Board of Governors of the American College of Surgeons and Senior Surgeon at Lahey Clinic, will speak on DIVERTICULITIS; and **Robert J Coffey MD**, Professor of Surgery at Georgetown University School of Medicine, will speak on NEOPLASTIC DISEASES OF THE COLON. Other participants on the panel will be **Arthur E Cocco MD**, **John N Diaconis MD**, and **J C Handelsman MD**, all of Baltimore.

WHY TREAT DIABETES will be the title of a discussion by **Marjorie Peebles-Meyers MD** of Detroit, Mich.

SEXUALITY AND THE PRACTICE OF MEDICINE will be discussed by **Mary S Calderone MD**, Executive Director of SIECUS (Sex Information and Education Council of the US). This will be the **Hundley Memorial Lecture in Gynecology**.

SELECTION OF DEFINITIVE THERAPY IN CANCER OF HEAD AND NECK will be the title for the first **Grant E Ward MD Lecture** to be presented by **Robert G Chambers MD**, Assistant Professor of Surgery at the Johns Hopkins University School of Medicine. The second part of this cancer panel will be on CURRENT CONCEPTS IN THE TREATMENT OF CANCER.

PROBLEMS OF SMELL IN MEDICAL PRACTICE will be the title of a discussion by **Robert I Henkin MD** of the National Institutes of Health.

NEWBORN EMERGENCIES will be the general title of a pediatric panel planned by **J Alex Haller MD** and **Marvin Cornblath MD** of the Johns Hopkins and University of Maryland Schools of Medicine respectively. The main speaker at this session will be **Jens G Rosenkrantz MD**, Chief of Pediatric Surgery at the Childrens Hospital in Los Angeles.

A FAMILY PRACTICE program will consist of a panel presentation of interesting clinical cases by the staff and residents of the University of Maryland School of Medicine, demonstrating comprehensive medical care. Participants will be **Edward J Kowalewski MD**, Professor and Head of the Family Practice Program; **J Roy Guyther MD**; Associate Professor, Family Practice Program; **C Earl Hill MD**, Assistant Professor in the Family Practice Program; **Peter Hartmann MD** and **William T Linthicum MD**, Junior Assistant Residents in the Family Practice Program.

RECOGNITION AND MANAGEMENT OF COMMON OCULAR PROBLEMS will be discussed by **Richard D Richards MD**, Professor and Head of Ophthalmology, University of Maryland School of Medicine.

STAGING AND TREATMENT OF LYMPHOMAS OF THE SKIN will be the subject of a lecture presented by **Richard K Winkelman MD**, Chairman of the Department of Dermatology, Mayo Clinic, Rochester, Minn.

NEWER CONCEPTS IN PLASTIC SURGERY is the title of the paper to be given by **F X Paletta MD**, Director of Plastic Surgery at Saint Louis University School of Medicine.

EVALUATION AND MANAGEMENT OF LUMBAR DISCOGENIC DISEASE will be discussed by **Rene Cailliet MD**, Professor and Chairman of the Department of Physical Medicine and Rehabilitation at the University of Southern California School of Medicine.

THE INEVITABLE REVIEW OF PHYSICIAN PERFORMANCE: HOW AND BY WHOM? This is the title of a presentation by **Alan R Nelson MD**, President of the Utah Professional Review Organization, Salt Lake City, which will be followed by a question and answer period. The Peer Review Committee of the Medical and Chirurgical Faculty and the Maryland Foundation for Health Care are cosponsoring this session.

POST-SURGICAL RESPIRATORY INSUFFICIENCY will be discussed by **T Crawford McAslan MD**, Professor and Head, Respiratory Division, Department of Anesthesiology and Center for the Study of Trauma, University of Maryland School of Medicine.

Additional information about speakers and subjects for this 175th Annual Meeting will be published in the April Journal. A complete program will be sent to all members of the Faculty several weeks prior to the Meeting and to others upon request.

ALBERT M ANTLITZ MD, Chairman
Committee on Program and Arrangements



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Medical Miscellany

ACS to Sponsor Trauma Seminars

Sixteen seminar programs to provide continuing education for nonspecialist physicians in Life-Saving Measures for the Critically Injured will be sponsored in 16 different cities throughout the USA in 1973 and 1974 by the American College of Surgeons' Committee on Trauma in cooperation with departments of surgery of medical schools.

The College has developed the Model Curriculum Content for a seminar program of four to five days' duration, designed to teach the most appropriate lifesaving diagnostic and therapeutic principles and skills for the treatment of the critically injured patient.

The departments of surgery will provide the individual seminars, gearing them to fill emergency medical care continuing education needs of physicians practicing in rural areas or where multi-specialty teams are not readily available. Though aimed at the nonspecialist general practitioner and emergency department physician, the seminars will be advantageous to surgical specialists and internists.

The seminar curriculum is divided into three broad areas:

1) Assessment of the critically injured and causes of death soon after injury—airway and respiratory problems, hemorrhagic shock, and brain damage.

2) Life-threatening injuries to the head, chest, abdomen and extremities.

3) Late life-threatening complications, including pulmonary insufficiency from nonthoracic trauma, impaired kidney function complicating patient management and complications following blood transfusions. Hyperalimentation and intensive care of the trauma patient also will be covered.

Seminar sites will be dispersed throughout the country to make one or more seminar easily accessible to all US physicians.

Detailed announcements showing registration fees, advance registration forms, and housing information may be secured from the Trauma Division, American College of Surgeons, 55 E Erie St, Chicago, Ill 60611.

Hospital Certification

The AMA again urged that hospital certification and recertification requirements under Medicare be rescinded because they serve no useful purpose. It made the recommendation in a letter to HEW's Health Insurance Benefits Advisory Council, now reviewing the effectiveness of these requirements.

Eliminating certification and recertification requirements would be a "step toward a desirable simplification of reimbursement mechanisms" and also would relieve physicians of "the burden of unnecessary documentation," the AMA said.

Kidney Foundation Research Grants

Applications for medical research grants in all aspects of renal disease are being accepted through April 30 by the Kidney Foundation of Maryland, according to C Robert Cooke MD, chairman of the Foundation's Medical Advisory Board.

Candidates must hold either an MD or PhD or equivalent degree in order to qualify for grants up to \$5,000. Sums awarded may be used for new or continuing projects or as primer grants with more extensive programs.

All applications will be reviewed by the Foundation's Medical Advisory Board and the Scientific Advisory Board of the National Kidney Foundation. Approved grants will be announced in June to become effective July 1, 1973.

Last year's recipients included Sylvester Sterrioff Jr MD, Assistant Chief of Surgery at Baltimore City Hospitals, who worked on the identification of human serum antibodies; and Robert M Ollodart MD, Associate Professor of Surgery at University of Maryland Hospital, who did a project in production and study of horse serum antibodies in transplant problems.

Information and application forms may be secured from the Kidney Foundation of Maryland, 809 Cathedral St, Baltimore, Md 21201.

Lung Cancer Clinical Studies

The cooperation of physicians is requested in the referral of patients for studies of lung cancer being conducted by the National Cancer Institute's Radiation Therapy Branch at the Clinical Center, National Institutes of Health, Bethesda, Md.

Needed are patients 55 years of age or younger who have a biopsy proven diagnosis of lung cancer, and who have not had radiotherapy or chemotherapy. Inoperable cases will be admitted for either radiotherapy or chemotherapy as indicated. Patients are also acceptable for consideration of postoperative radiotherapy following a potentially curative resection. Under selected conditions, patients with known metastatic disease will be admitted.

Physicians interested in having their patients considered for admission to these studies may write or phone Kent B Lamoureux MD, Clinical Center, Room B3B-38, National Institutes of Health, Bethesda, Md 20014, phone 301-496-5457.

Stop Smoking?

A group of 12 hard-core smokers who found it difficult to stop even though there may be serious health hazards involved is involved in a new approach by the Bureau of Mental Health of the Baltimore County Department of Health.

According to Mehdi L Yeganeh MD, director of the Mental Health Bureau, the pilot program, led by a psychiatrist, uses group therapy to enable smokers who have previously tried to abstain to adjust to withdrawal from the use of tobacco.

Dr Yeganeh emphasizes that this is not a quick, easy panacea. The usual period of mourning is said to be six months, the duration set for the group therapy sessions. If successful, it will be made an ongoing program.

Family Practice Residencies

The American Academy of Family Physicians' recent annual survey of family practice residency programs shows that 1,015 young graduates are training to be family physicians.

This figure almost doubles the number enrolled in family practice residency programs a year ago. It is three times more than were in training in 1970.

The survey also indicates that 81% of the available first-year family practice residency slots are filled, bettering by 10% the figure in 1971. This percentage of filled first-year slots is higher than that for most other medical specialties.

Three years ago, there were 20 approved programs. There now are 107. Currently there are 34 departments and 31 divisions of family practice in the nation's 105 medical schools.

Blindness Prevention Research Grants

The National Society for the Prevention of Blindness announces that it has research funds available for pilot projects which do not exceed \$5,000 per year. Investigators not currently financed by other sources of research funds are invited to apply.

Acceptable projects are those which may contribute to the prevention of blindness and eye disease through basic studies of eye function and disease, or that may improve diagnosis and treatment.

Grants are made for a one-year period. The maximum period of support for research is two years. Applications are accepted at any time.

Application forms and further information may be obtained by writing to the Committee on Basic and Clinical Research, National Society for the Prevention of Blindness Inc, 79 Madison Ave, New York, NY 10016.

Medicare Premiums

The premium for the supplementary medical insurance part of Medicare will be \$6.30 a month beginning July 1, up 50¢ over the current level.

The supplementary medical insurance program complements the basic hospital insurance part of Medicare by helping to pay physicians' bills and a wide variety of other medical expenses in and out of the hospital. The costs are shared by the participants and the Federal Government.

About 22.5 million persons will be enrolled in the program in the coming fiscal year, including 1.7 million disabled persons under age 65 who are newly covered by recent legislation.



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HOLY CROSS HOSPITAL OF SILVER SPRING

Built at a cost of nearly \$9 million, Holy Cross Hospital of Silver Spring observed its tenth anniversary on Jan 10, 1973.

A voluntary, not-for-profit, general hospital, it is administered under the auspices of the Congregation of the Sisters of the Holy Cross.

The 338-bed hospital is located on a ten-acre site at 1500 Forest Glen Road and borders the Capital Beltway in Montgomery County, just a few miles north of the District of Columbia boundary.

The modern hospital must be a viable and dynamic in-

stitution capable of adjusting to the changing medical, economic, and social factors at work within and outside its walls.

Holy Cross Hospital has done so. Assuredly it is not the same institution which first opened its doors on Jan 10, 1963.

The addition of 116 patient beds and extensive remodeling to create new areas for specialized services illustrate the physical changes.

Special care units provided in the hospital are an eight-bed Coronary Care Unit, a four-bed Cardiac Telemetry

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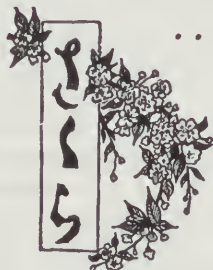
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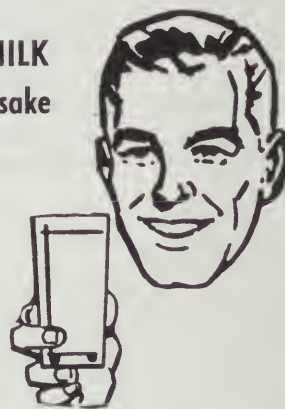
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MRS ROBERT A REITER
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woman's auxiliary

WORLD-WIDE ERRANDS OF MERCY

The Powder Puff Derby girls, those intrepid lady pilots who fly transcontinental races, do serious work, too. The "Ninety-Nines," their organization, has offered to fly medicine and supplies collected by the Woman's Auxiliary to the American Medical Association to their destination without charge. This, indeed, is a wonderful service, for the Auxiliary, through its International Health Activities Committee, collects large quantities of such material for use in destitute areas.

The Auxiliary's International Health Activities Committee was formed in June 1961, after Dr Louis Orr, President of the AMA in 1960, visited Bangkok and became interested in their leprosy relief program. On his return he challenged the Auxiliary to find a way to help. The International Health Activities Committee was the result and its basic program headlined "Service to a world-wide medical community." It instituted collection programs covering all medical discards and a program to provide hospitality to foreign doctors studying in American hospitals. Through the years since, the Committee has grown to include many services.

The national IHA Committee of the Auxiliary has a list of 17 agencies, such as church mission boards, relief organizations, and medical assistance groups which need supplies; it makes this list available to each of the state auxiliary chairmen. The state chairmen also receive long lists of needed supplies which are collected through the county auxiliary IHA committees and shipped to their destination. Shipping costs are high; therefore the need to find free transportation. This is where the "Ninety-Nines" come in. Sometimes the Navy is able to take shipments through its "Project Handclasp" program.

Here in Maryland, Baltimore County Auxiliary IHA Chairman Mrs Charles H Williams was

able to have United Fruit boats take shipments to Honduras. The National IHA Committee also maintains a register of organizations which need physicians and paramedical personnel. Thus, county IHA chairmen are able to put doctors willing to spend their vacations in underdeveloped areas in touch with the proper agency.

County auxiliaries raise money for special IHA projects, such as buying pieces of equipment for mission hospitals or aiding the Ship Hope. Currently, IHA is raising money to help educate the children of doctors in underdeveloped countries. When doctors in India, for example, must leave the cities where they can earn a living and go into the poverty stricken countryside, they are unable to earn enough to keep their children in school. Here in Maryland our IHA State Chairman, Mrs Arthur S Bauer of Allegany County Auxiliary, has asked each of our 12 counties to provide \$30 for this one project as \$360 is the sum needed to support one child for one year. The Eastern Regional District, whose IHA Chairman is Mrs H Leonard Warres, is currently educating a physician's child in the Dominican Republic.

Our Maryland Auxiliary has achieved notable results in giving aid through IHA. Last year \$500 was given to the Ship Hope. Tons of needed supplies were collected by the various counties and members spent many hours sorting and packing and then in finding means of transporting them. From Baltimore County, Dr and Mrs Charles H Williams did—and are still doing—an outstanding piece of work in collecting and shipping truckloads of equipment and medical supplies for a needy hospital in Honduras; they have also spent their vacations working in this hospital.

Baltimore City Auxiliary's IHA Committee maintains a translation team to aid foreign-

language patients in hospitals communicate with their doctors. Baltimore City's IHA Chairman, Mrs Israel Zeligman, works in cooperation with the Baltimore Council for International Visitors to help the wives of foreign doctors adjust to and find their way in Baltimore City. She has formed a group of these wives and helped them get transportation to the English language classes given by the YMCA.

These are but a few of the projects undertaken by the IHA Committee of the Woman's Auxiliary, but they are enough to show the Med-Chi members and doctors wives who are not Auxiliary members, what we are doing around the world.

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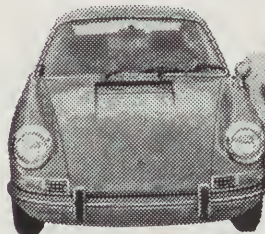
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THE FUTURE EMPHASIS OF MENTAL HEALTH TREATMENT

BERTRAM PEPPER MD

Director, Mental Health Administration

NEIL SOLOMON MD PhD
Secretary

Maryland State department of health and mental hygiene

As a result of State governmental reorganization accomplished over the last three years, the Department of Mental Hygiene is now one of the nine administrations of the State Department of Health and Mental Hygiene. As is usually the case with reorganizations, the problems faced remain essentially the same, while the names change, and the resources and techniques available to meet the problems are, hopefully, improved.

The basic work to be done remains at least as staggering to contemplate as before; perhaps even more so, as changing times and new citizen demands create new opportunities for services developing in new ways. The Mental Hygiene Administration presently supervises the operation of both the regional and the specialized State Mental Hospitals, the Psychiatric Research Institute, and the Program of State Grants to counties for Community Mental Health Services.

Last Decade's Plan for Change

In the 60s, guided by the Congress and NIMH, Maryland planned a network of comprehensive community mental health centers which were to eventually serve all residents of the State and take over some of the traditional functions of the State hospitals. This was to allow the gradual reduction of each of the large State hospitals to 1000 beds. But when the decade of the 60s left us, so did the commitment of the Federal Government to provide funds for that network of comprehensive community mental health centers.

Despite the commitment of the Congress of ten years ago to fund a complete network of centers for the entire country, the present administration is in the process of changing the community mental health center program to the status of a pilot or demonstration project. The real thrust toward Federal support of mental health services, we are led to understand, will be in the direction of mental health being a component of total health care in the yet-to-be-designed, yet-to-be-legislated, yet-to-be-funded,

health maintenance organizations, or prepaid group practices, or whatever title is finally decided on for the next set of programs which will revolutionize our work.

With our unlimited optimism, modified by our actual experiences, we recommend that Maryland not wait for the Federal Government to come and provide us with the wherewithal to review and modify our current mental health system as Maryland's contemporary demands may require. Rather, the Department of Health and Mental Hygiene is looking into present resources, in a time of barely increasing absolute dollars and relatively shrinking dollars on the scale of purchasing power, to reconsider our priorities for current program expenditures, develop methods for providing better input and fusion of consumer and professional concerns and priorities, and update the Mental Health care system to keep abreast of contemporary technologies, service needs, and manpower resources.

The greatest volume of public mental health services in Maryland today continues to be provided by the four Regional Mental Hospitals. As is the case with most psychiatric hospitals in this country today, they find that their staffs, moderately increased over the last several years, are increasingly overburdened by an ever-growing number of admissions. While the average census of the hospitals has declined slightly in the past year, the decline is no longer very significant in terms of decreasing the workload.

What is significant, in terms of *increasing* the workload, is the continuing increase in the number of admissions. Many of these continue to be inappropriate for hospitals of this kind, from both a clinical and humane perspective. That is, approximately 50% of the admissions are inebriated alcoholics who need detoxification and medical care. Thereafter, a percentage may require a rehabilitation program which can be provided in a community setting or in a state hospital setting. However, the medical-surgical facilities of the State hospitals are not adequately

equipped or staffed to take care of the severe medical complications of some of the alcoholic admissions, and the location of these hospitals makes them unnecessarily removed from the home community of the alcoholic patient when the need is for simple detoxification.

Parallel to the comments regarding alcoholic patients, the Regional Mental Hospitals remain, in some areas of the State, an inappropriate resource for the hospitalization for elderly persons who do not have an actual need for psychiatric hospitalization, but who may require domiciliary care, nursing home care, or general hospital medical care. Further, after such elderly individuals are admitted to the State hospital and their presenting difficulties have been attended to, they present severe problems in placement in domiciliary care or return to their community; as a result it is estimated that perhaps 1500 elderly persons are continuing to remain as State hospital patients despite the fact they no longer require psychiatric hospitalization. The reason is simple: they *do* require care, and other, more appropriate facilities and resources are simply not available. We should not delude ourselves that these two categories of patients, alcoholic and geriatric, are receiving appropriate kinds or levels of care in the State hospital, whether or not they may be appropriate for admission from our perspective.

The plain fact is that the facilities, resources, and available staffing are not sufficient to meet the needs of these groups of patients. The chief advantage to the community at large of these hospitalizations is that they remove from view the fact that appropriate care resources are not available.

Emergency Psychiatric Services for Baltimore City Residents

In November 1972, Maryland took a long step forward in bringing psychiatric emergency care for City residents out of the 18th century. Until November, with the initiation of a new psychiatric Screening and Evaluation Unit, operated by the State Mental Hygiene Administration and located at the Mason Lord Building ("D" Building), City Hospitals, more than 3000 psychiatric crises per year were being dealt with by incarceration in the police lockups, for want of a hospital-based, medical and psychiatrically operated screening unit available to all residents of the City.

For the last several years the State has operated a transportation unit, carrying patients from the police lockups to the State Regional Mental Hospitals. Basically, the acute psychiatric emer-

gency patient who could not afford private hospitalization and who lived in Baltimore City was brought to a lockup, perhaps spent the night, and then was taken to a State hospital. Despite efforts of the last several years to secure funds for the development of a hospital-based screening and evaluation unit, such funds were simply not made available, due to budget exigencies. However, on assuming the position of Commissioner of Mental Hygiene in July of 1972, it was determined after a preliminary review of the Maryland mental health scene, that the continued use of the lockup as a basic response to psychiatric emergencies did not allow for the development of confidence in or credibility of the mental health program. Therefore, with the fullest support of the Secretary and other key members of the Department of Health and Mental Hygiene, we re-allocated funds from existing programs to make a prompt start at the long overdue and desperately needed screening and evaluation program.

The new program is not the final answer to the needs of the Baltimore City population for acute psychiatric services. Looked at from a historical perspective, the move from jail to city-wide screening in a public hospital brings Baltimore into the first part of the 20th century. However, contemporary psychiatric care systems in large municipalities, both in the United States and in Europe, have striven to eliminate such city-wide programs, in favor of multiple, locally-based psychiatric emergency care systems which are backed up with their own array of services, as needed. This array necessarily includes, but is not limited to, the availability of inpatient hospital care.

We thus see ourselves, in the next phase of development, moving to support and strengthen the development of community mental health centers in Baltimore City, particularly in regard to their developing adequate emergency services. The staff at the Screening and Evaluation Unit has been working closely with the staffs of the emerging Community Mental Health Centers, from opening day, with the explicit purpose in mind of putting themselves out of business in favor of a multiple-location emergency psychiatric capability in the various communities which comprise the City of Baltimore.

We thus hope to demonstrate that the practical, American way of getting things done, that is, doing them one way for as long as it makes sense, and then doing it another way, *can* be applied to governmental structures as well as to private enterprise.

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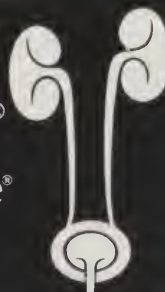
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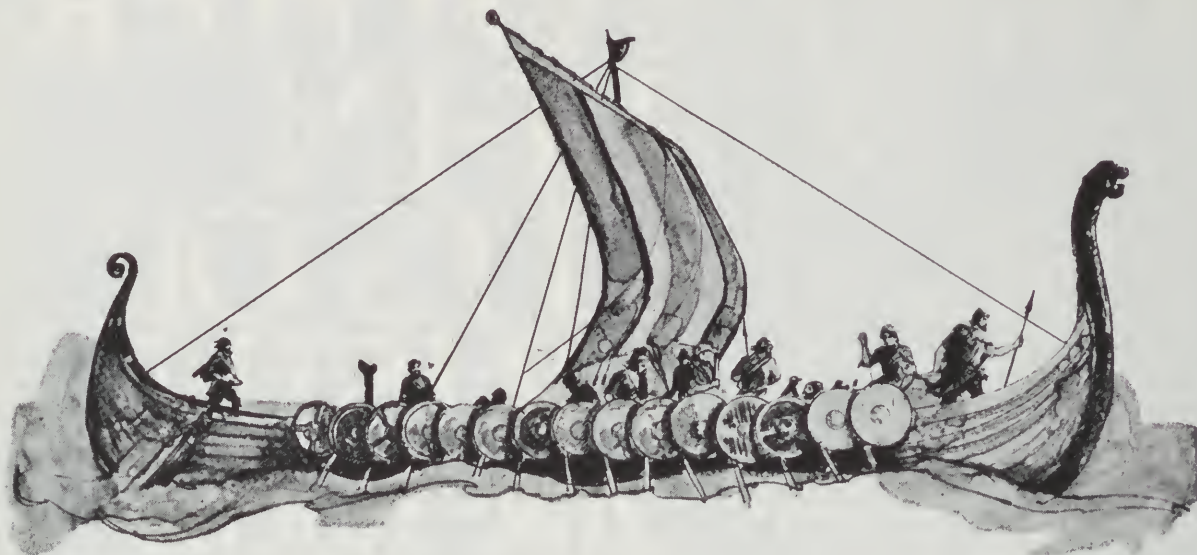
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MEDICAL LITERATURE IN THE EARLY 19th CENTURY

DOUGLAS CARROLL MD

Baltimore City Hospitals

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"Medical theorists had gone from extreme to extreme in constructing their systems. One group would begin its work by constructing a truly overwhelming nosology. Every supposed variation of a disease and every imaginable combination of symptoms would be named a distinct species, and each would be said to require its own elaborate treatment. Pulmonary tuberculosis, for example, by many theorists was broken down into 20 different species. Reacting to these excesses, and the consequent impossibility of practicing within such a framework, other theorists proclaimed that there was but a single disease, manifesting itself in different states. Each of these theorists, of course, had his own ideas concerning the seat of disease, its cause, and the single treatment appropriate for every manifestation of illness.

"Under such conditions as these, theoretical doctrines had risen and fallen in such rhythmic succession that a sober onlooker could not be blamed if he came to look askance at theory per se."

George H Daniels. American Science in the Age of Jackson.

The medical literature of the 18th century in the American Colonies was of three main types. The first was directed to the population as practical advice on how to meet common medical problems, such as epidemics occurring in the community. This type often appeared in the local newspaper.¹⁻³ A second type of medical publication was supposed to make a contribution to the world scientific community. These reports were sometimes in the amazing case category,⁴ but often were concerned with descriptions of a meteorologic⁵ or natural history phenomena of the New World.⁶ These communications were published in the Philosophical Transactions of the Royal Society or the Gentleman's Magazine.

The third type of medical literature was the monograph, usually by a European educated physician, on some local medical problem.⁷⁻⁹ These monographs were printed at the author's expense and were a contribution to current diagnosis and treatment of the disease described. They were characteristically summaries of the European authorities, strong in opinion, often dogmatic, and extremely weak in direct observation and case reports. Indeed, one frequently wonders whether the author has really seen any cases of the disease described.¹⁰ A variation of this monographic summary of the literature was the medical student dissertation required in certain Colonial

medical schools.¹¹ By and large, these were deadlly dull summaries of the literature, now deservedly forgotten.

The publication of an American medical periodical, the *New York Medical Repository*, in 1797 was part of the new spirit of the Enlightenment which, along with other developments in America (such as the separation from Europe, the increasing importance of American medical schools, the rise of medical societies, and state medical licensure), was a manifestation of the growing independent course of scientific interest in America.

Medical Repository was the first of a long series of medical journals to emerge. It was published between 1797 and 1824. By the time it ceased publication, 40 new medical journals had been founded. Prior to 1850, 213 different medical journals had been published, but there were many fewer editors than journals because one man founded (and saw the demise of) more than one journal. John Eberle was connected with six journals, John D Goodman, John Bell, and Isaac Hayes all started several journals.¹²

Medical journals developed along with medical schools and full-time men in science and medical schools. In the 50 years following the death of Franklin and Rittenhouse "there was nothing worthy of the name of national science" in Simon Newcomb's words.¹² Around 1815, American interest in science began to emerge; colleges and universities began to flower; trans-

This is the seventh of an 11-part series of articles on the history of medicine in Maryland from 1634 to 1835 as written by Dr Carroll.

portation and communication improved. Between 1808 and 1821, 16 new colleges were founded in America, and in the following decade 23 more.

The prototype scientific man of the 18th century was the gentleman amateur. Science taught in the colleges was taught by a natural philosopher, and he taught what we call general science today. The natural philosopher had broad interests, and by the early 19th century it was impossible for one man to encompass the whole of science. In 1802 Yale had a professor of Mathematics and Natural Philosophy who taught all sciences including chemistry and natural history. Benjamin Silliman was appointed in that year to the new Chair of Chemistry, Natural History and Mineralogy, separated from the old Chair of Mathematics and Natural Philosophy. When Silliman retired in 1853, the Chair was divided again, and in 1864 a Professor of Botany and Geology was founded in addition. In the meantime the original Chair of Mathematics and Natural Philosophy had been split in 1836. In 1802 there were about 21 full-time scientific positions in the United States. By the 1820s there was a flourishing scientific community with adequate resources for publication, and the beginnings of professional and institutional structures.

George Daniels¹² in his study of American science during the age of Jackson has selected 56 distinguished American scientists of the time and analyzed their education and contribution. Of these, 27 had medical training in colleges; 20 had collegiate training other than medical; nine had not gone to college; 21 had European education, with Edinburgh accounting for six; Paris, six; England, three; and Italy and Holland, one each. Forty-one were professors of science, five were employed as scientists in nonacademic positions, three were practicing physicians.

There were few important contributions to medicine by American physicians during the early 19th century. Indeed Nathaniel Chapman in 1820 founded the *Philadelphia Journal of Medical and Physical Sciences*, in an effort to answer Sidney Smith's derogatory remarks on American culture made in the *Edinburgh Review*. Phyllis Allen Richmond¹³ has attempted to identify the important fundamental research performed by Americans in the 19th century. Of 100 examples chosen, 18 were contributions to practical medicine. Of the Maryland physicians mentioned, all except Elisha Bartlett (1804-1855) were associated with the Johns Hopkins University late in the century. Bartlett is cited for his work on typhoid and typhus (1842) and fevers (1847). Since he was in Baltimore for less than

two years (1844-46), one can hardly speak of his contributions as originating in Maryland.

The *New York Medical Repository* was the first American medical journal available for contributions by local practitioners. Under the editorship of Samuel L. Mitchell, it enjoyed an excellent reputation and circulation between 1797 and 1824. It brought new European medical knowledge to America, such as Lavoisier's chemical revolution and Joseph Priestley's contributions. There were also articles on current problems such as yellow fever,¹⁴⁻¹⁶ book reviews,^{17,18} measles,¹⁹ ornithological articles,^{20,21} reports of epidemics,^{22,23} and procedures.²⁴

Medical Journalism in Baltimore

1) The Baltimore Medical and Physical Recorder (1808)

Of the 12 Baltimore medical journals started between 1808 and 1880, only one lasted through volume six.²⁵ The journals were not established to make money, were poorly managed, and relied too heavily on local support.

The *Baltimore Medical and Physical Recorder* was the first medical journal in Maryland and the third in the United States. It was started in April 1808 under the editorship of Tobias Watkins (1781-1855). It was an excellent scientific journal, far ahead of its time. Unfortunately, it completed only five quarterly issues.

Perhaps the most important contribution was that of John Crawford (1746-1813), *On the Seats and Causes of Disease*.²⁶ Crawford had previously presented some of his major ideas as to etiology of diseases in the newspaper,²⁷ in his own privately printed magazine,²⁸ and in a monograph.²⁹ His reasons for publishing so widely and in the newspapers is given at the beginning of his articles: "It is of the highest importance that the community at large should be made acquainted with what is so materially the concern of every individual, and, it cannot fail to be highly advantageous, both to the physician and to the patient, to be united in their opinion as to the cause of disease."

In this remarkable essay, Crawford, drawing from his wide experience, and with careful reasoning, concluded that infectious diseases were carried by insects or their larvae. This was an unpopular and unaccepted view during Crawford's lifetime, and may only have been published because of Crawford's close friendship with Watkins.³⁰

There are other features of Watkins' magazine which made it ahead of its time. Extracts from Bichot's "Physiological Researches" appeared in several issues, pointing toward the growing im-

portances of the French School of Medicine and the autopsy. There are a number of case presentations by Watkins with autopsy reports on patients admitted to the Marine Hospital between Jan 1 and June 30, 1808. Admissions to the Marine Hospital are listed by diagnosis and analyzed. There are also a few local medical news items. Some of the interesting articles are as follows:

Rules for the recovery of the apparently dead
by James Cooke

The cold plan for the treatment of measles
by Cosmo G Stevenson

Fistula in ano healed by mercury by Nathaniel Potter

Indigenous medicinal plants by Tobias Watkins

An essay on means of rendering whole the atmosphere of large cities

Tobias Watkins (1780-1855) was born in Anne Arundel County, went to St John's College, completed a preceptorship in medicine, and served as a naval assistant surgeon from 1799 to 1801.³¹ He began practice in Baltimore about 1803 and was appointed Physician to the Marine Hospital.³² Watkins includes a number of reports from the Marine Hospital in his magazine. There were descriptions of common diseases: ascites and anasarca, syphilis, and diabetes. There is an autopsy report of one case. This seems to be the earliest reported hospital autopsy in Baltimore, although Charles Frederick Wiesenthal apparently performed autopsies in his school, and autopsies may have been performed at the almshouse prior to 1808. One of Watkins' earliest papers was on the treatment of hemorrhoids with pokeberry juice.³³ Watkins' reports indicate that the Marine Hospital of 1808 took general cases, but its location, auspices, and fate are not clear.

Watkins returned to military service in 1813, and continued in the service until he reached the grade of Assistant Surgeon General in 1818. In addition he was Grand Master of the Masons, 1813-1814, and High Priest, Encampment of the Knights Templar, No 1 in 1812. From 1824 to 1829 he was fourth Auditor of the United States Treasury, Washington. In this position he got into trouble, being convicted in 1829 of appropriating public money. He served a prison sentence from 1829 to 1833 and died in 1855.

* * * *

As an historical document, the *Baltimore Medical and Physical Recorder* reveals the very best in the new scientific thrust of American Medicine. The recognition of the importance of

case study, the use of the postmortem examination, the interest in understanding mechanisms of disease rather than in treatment, the absence of dogmatism, and the commitment to the new French School of clinical-physiological-pathological correlation are a decade ahead of medical scientific thought in Baltimore. Not until the clinical pathological correlations of Thomas H Wright at the Baltimore Almshouse in the 1820s do we find the thread of medical scientific advance taken up again in Baltimore.

2) Nathaniel Potter and the Baltimore Medical and Philosophical Lycaem (1811)

The second Baltimore medical journal was founded by Nathaniel Potter (1770-1843) in 1811 about two years after the demise of Tobias Watkins' *Baltimore Medical and Physical Recorder*. Perhaps the Prospectus³⁴ is the most important part of a volume of somewhat over 400 pages, for it reveals the changing nature of medical knowledge.

Potter denies any hope of making money from such a venture; indeed he suspects that subscriptions will not be able to cover expenses. Despite this he feels that there is an important place for a medical magazine in Baltimore because of the number of distinguished philosophers and physicians "whose talents are resting in obscurity for want of use." The establishment of a medical school and the recent discontinuance of Dr Watkins' *Medical Recorder* suggest the necessity for a periodical work. The high cost of books makes such a venture useful. Potter promises to summarize the best European books in his periodical.

He hopes to publish the results of postmortem examinations, particularly in regard to whether diseases are local or general. His own opinion is that most are primarily local. He believes that this question can be determined by dissection. A second important field which he wishes to cover is that of experimental medicine. He hopes that experiments may clear up controversial points now left to visionary hypotheses and conjecture.

He sees the importance of chemistry and is interested in how certain diseases seem to be associated with certain soils. The character of the atmosphere is of importance not only to the physician but also the philosopher and citizen. The uses of the animal, vegetable, and mineral resources of the country are important not only to the physician and naturalist but also to the manufacturer. He hopes that some of the resources available in America can be discovered and used in local industry.

Lastly he is interested in the importance of mineral springs which have been discovered

throughout the country, but especially in Maryland. These waters should be chemically analyzed and their virtues studied empirically.

Potter was a close friend and favorite pupil of Rush, receiving his medical degree from the University of Pennsylvania in 1796. He was therefore a member of the older generation of physicians during the golden age (1828-1850) of Medicine in Baltimore. His ideas of cause of disease were formed under the influence of Rush and he used the lancet and calomel freely. He was a fearless experimenter, innoculating himself with perspiration and pus (1798) from patients with yellow fever in a demonstration that the disease was not contagious. His greatest contribution was to the founding and development of the University of Maryland School of Medicine.³⁵

Yet the Prospectus reveals his acceptance of the new contribution of the dissectors. He believes that the autopsy is the backbone of new medical knowledge. Further, he is ready to accept the possibility that diseases are local, rather than general in origin, thus departing from Rush's teaching. Although he hopes to publish work of both the dissectors and the experimenters, there is actually no postmortem report in the journal. The researchers, however, are represented by reports on the work of Humphrey Davy and Priestly's work on Oxygen. Other eminent European scientists are represented.

Mr Charles Bell, FRSL, of London writes on neuroanatomy, reassuring the reader that he is not seeking the site of the Soul, as many have claimed—"all ideas originate in the brain: the operation producing them is the remote effect . . . on the extremities of the nerves of sense."

The experiments of Mr Legallois MD, of Paris, are translated from the *Paris Moniteur*. He notes that decapitated animals have continuous heart beat if they are ventilated artificially. Therefore, the principle of action of the heart must reside in the spinal marrow.

Analysis of animal fluids and secretions by "electrochymical decomposition" are described by Everard Home, FRS.

There is an excellent clinical description of diagnosis and treatment of Stramonium poisoning with Jamestown Weed by Richard Hopkins.

New treatments include the use of cotton on burns and dilation of the female urethra.

A number of local authors are represented. Thomas H Wright describes the *Malignant Fever at Elkridge Landing* and its vicinity. These cases were characterized by vomiting, some producing

coffee ground material, so that the possibility of yellow fever had to be considered. Few developed jaundice, however, so that malaria seems today to be a good possibility. When one member of a family got the disease, all sooner or later developed it. Wright noted that he frequently developed nausea, headache and tachycardia when he entered a house with sick people. This is one of a number of inconclusive descriptions of febrile illness in which it is impossible from the information given to identify the disease. Probably many diseases, with malaria dominant, were present in what seemed to be epidemics. We will see Thomas H Wright at a later and more important era in the development of medicine.

Potter himself has an article on the *Anomalous Character of Measles in 1808*. Other local Baltimore authors include Williamson on *Scrofula*, Richard W Hall on *Influenza*, William Harsnepe on *Canine Madness*, a second article by Thomas H Wright on *Prussate of Iron in Uterine Hemorrhage*, and John B Davidge on *Aneurism*.

Perhaps the most satisfactory case report is about a patient shot in the trachea with subsequent expectoration of the bullet.

* * *

The *Baltimore Medical and Philosophical Lyceum* folded after four quarterly issues. As a proving ground for local authors, it perhaps justified itself. From any other viewpoint, it added little of importance to medical knowledge or practice.

3) John B Davidge and the Baltimore Philosophical Journal and Review (1823)

This short-lived journal is another example of high hopes dashed by economic realities. John Beale Davidge (1768-1829) also played an important part in the founding and nurturing of the School of Medicine.³⁵ He was stiff, affected, and without inspiration to his students. The journal was started just before the new Infirmary at the Medical School was to open. It may be that Davidge hoped that the journal would publish material from the Infirmary and be the scientific voice of the Medical School. The introduction presents the importance of student teaching, correlating the "precept of the school, and the illustration of the hospital." Hospital-based medical teaching was an old tradition in European countries, but there was no example of close coordination of teaching and observation in America. Even the University of Pennsylvania Medical School did not have a University-controlled hospital until 1874.³⁶ The students of the time used the "City-Hospital" (the Maryland Hospital, then on the site of the present Johns Hopkins Hospital) and the Almshouse (at How-

ard and Biddle streets) but these were miles from the Medical School and did not substitute for an Infirmary clearly associated with the College of Medicine. "The object of a clinical Infirmary is, to teach personal observation." The Infirmary is to open Nov 1, 1823.

The remainder of the journal is divided between reprints of foreign and ancient articles and local case reports. The first article is a translation of M Pouppe Desportes' article on the *Disease of Siam or Yellow Fever* consisting of ten case reports. A criticism of the use of mercury in fever was offered by Ezra Gillingham (1825) of Baltimore. The case of a child who aspirated a seed of rye and developed a fistula through the chest wall with final extrusion of the seed is of interest.

Davidge himself contributed two case reports, one on the use of splints in femoral fractures and the other on removal of the parotid gland.

* * *

The journal marks a point of great importance in the development of medical teaching, namely, the use of the hospital as the laboratory for physician training. Organized medical teaching in America had started with preceptorship with physicians in private practice.

As early as 1790, with the founding of the first Medical School in Baltimore by Drs Andrew Wiesenthal and George Buchanan, the Almshouse had been used for patient material, but not as a central teaching resource. The University of Maryland started using the Almshouse early after its founding, probably as early as 1808 in the first class,³⁷ but again it was not considered of essential importance.

4) Horatio Jameson (1718-1855) and the Maryland Medical Record (1829)

In September 1829, under the editorship of Dr Horatio Gates Jameson, a quarterly—the *Maryland Medical Recorder* was founded, but closed with Volume II. Jameson had unlimited energy. He started practice in 1795 at the age of 17, having served a preceptorship with his father, an Edinburgh-trained physician practicing in York, Pa. He married two years later and had nine children. His four sons all became physicians. He traveled around western Virginia and Pennsylvania before settling in Baltimore in 1810. He attended lectures at the University of Maryland and graduated in 1813. He held a number of important positions including Consulting Physician to the Board of Health from 1821 to 1835.

He was considered one of the most brilliant of the young medical school's graduates. Apparently he was promised a faculty position before he graduated, but his appointment was opposed by the

equally brash, abrasive, and ambitious Professor of Surgery, Granville Sharp Pattison. Jameson, bitter and ambitious, split the medical school and founded his own school, Washington College (1827 to 1851).^{31, 35} That he was a daring master surgeon is supported by no less an authority than Dr Samuel Gross. Within a few years of graduation he had written a handbook of medicine for family use.³⁸ He wrote well on infectious diseases, was a pioneer surgeon and an authority on yellow fever, having been invited by special invitation to speak on the *Non-contagiousness of Yellow Fever* before the Society of German Naturalists and Physicians of Hamburg in 1830.

Possibly his greatest contribution was *Observations upon Traumatic Hemorrhage* published in *Medical Recorder*.

Volume I of the *Maryland Medical Recorder* (1829) is a thick closely-printed volume of 773 pages. Its stated purpose is to collect and record original views on medical subjects. It consists largely of case reports with reviews of the literature. Many of the reports are from local physicians, and Jameson himself contributed a great many. There are a number of reports of surgical procedures, laminectomy in paraplegia, trepanning of the skull. One of Jameson's articles was on tumors of the upper jaw, recommending ligation of a single, or, under certain circumstances, both carotid arteries. Indeed the articles are largely surgically oriented, although Jameson himself contributed an article on typhus fever, and there are articles on the relation of chemistry to medicine, and book reviews. The Glustonian Lectures on elements of medical statistics are summarized, and there is a section on the statistics of suicide.

At the beginning of the third number, Jameson reports an increase in numbers of subscribers and seems well satisfied with the progress of the journal. However, this number contained five articles by Jameson and three by Richard N Allen (1796 to 1833) of Bel Air, Md, suggesting a dearth of available writers.

The volume contains news from the Washington Medical College (names of students, graduates for the year 1830), a notice of Dr John B Davidge's death with a biography.

There is little material on new methods of diagnosis, little on the new disciplines entering medical education, and no emphasis on postmortem findings. It is rich in descriptions of heroic surgical procedures.

5) Nathan R Smith and the Baltimore Monthly Journal of Medicine and Surgery (1830)

In February 1830, Dr Nathan R Smith (1797-1877) started the first monthly Medical Journal in Maryland, *The Baltimore Monthly Journal of*

Medicine and Surgery. This journal was discontinued after the second volume, which, however, was the longest run of a medical journal in the State to that time. It is a monument to the remarkable energy, vigorous style and wide knowledge of Nathan R Smith.

The prospectus by the editor observes that Baltimore deserves a medical magazine because it is a large city and has a school of medicine. In a footnote the author states that at the time the prospectus was written he had no knowledge that any similar journal was being contemplated.

The frontpiece is a picture of John Doane Wells MD, late Professor of Anatomy at the University of Maryland Medical School. The title page has a picture of the University of Maryland Medical School, and the editor requests aid from the alumni. The cost of year's subscription was three dollars in advance, four dollars if paid at the end of the year.

There were four departments: Original Essays, Analytical Reviews, Adversaria (brief articles of original intelligence), and monthly summaries of foreign and domestic articles.

Smith, himself, reports a case of strangulated hernia, seen in consultation at the Baltimore Infirmary with Potter, Hall, and Baker. The patient was treated (and cured!) by bleeding, starving, and cathartics. A review on Scrofulous Disease and a series of articles on the use of heat and cold constitute the analytical section.

In the section on Abstracts of Domestic Medicine, Smith reports on the latest volume of the *American Journal of the Medical Sciences*:

"The great object of competition among editors seems now to be, to present their readers with the greatest number of closely printed pages. Is not this a pitiful ambition? Within ten years, journals have grown to twice their former size. This would be less startling if modern invention, so fertile in new devices, could only double the speed of our eyes and intellects in reading a book; but, unluckily, although there are machines which print both sides of the sheet at once, there are no spectacles through which we can read and understand both sides of a leaf at the same moment."

Dr Marshall Hall proposes an investigation of blood letting.

"No remedy is now more general—not even calamel or blue-pill—and this fact may assure us that no remedy is more abused."

A committee of the Connecticut Medical Society respecting an asylum for inebriates is quoted: "The propriety of making any provision for inebriates might well be questioned, if intemper-

ance were not a misfortune as well as a crime—if the lover of strong drink, was not himself the victim of wretchedness from which he would gladly escape. The members of this society need not be told, that intemperance is commonly associated with disease of body and mind—and although the disease is aggravated, and probably occasioned by vicious habits, those very habits are adhered to, because they are thought to yield momentary relief from suffering

"Under these circumstances, it becomes us to inquire whether the evil is not of so much importance as to demand the corrective aid of government, and the untiring efforts of benevolent individuals to affect its removal. Instead of sending a drunkard to a work-house for punishment, we would have him sent to an asylum for reformation: and instead of 30 days confinement, we would require him to devote at least a year to the great and important work of reformation."

The end of the volume includes an obituary on John Doane Wells MD, starting with a poem on Wells by Smith and ending with the postmortem findings. This, incidentally, is the only original report of an autopsy in the volume and was requested by Wells.

Finally, Smith ends with an excellent critique of Caldwell's Boyleston prize essay, *Thoughts on Febrile Miasmas*.

In brief, the volume contains very few original articles other than those of Smith himself. The remainder consists of abstracts from other journals. Possibly the lack of original material explains why a purely local journal dependent on a medical school could not compete with a national journal such as the *American Journal of the Medical Sciences* which had been developing for 12 years and had wide support in the Eastern cities.

6) Eli Geddings and the North American Archives Medical and Surgical Science (1833)

1833 saw the launching of Baltimore's sixth medical journal. The editor was E Geddings MD, (1799-1878) Professor of Anatomy and Physiology in the University of Maryland, "supported by an Association of Physicians and Surgeons." The editor outlines his motives as improvement of the profession. He hopes to incite physicians to diligent and careful investigations and to record the results of their experience. True, other journals are doing the same thing, but "more still needs to be done." The *Baltimore Medical and Surgical Journal and Review* is to have nothing of a local character: it is to furnish everything of practical interest. Strangely enough these staggering expectations were fulfilled, although the journal had only two volumes. It is a remark-

ably modern, critical, and comprehensive medical review, with clinical-pathological orientation.

Nathan R Smith opens with a discussion of fracture of the thigh and leg, using the same figure illustrating his orthopedic traction apparatus as appeared in the *Baltimore Monthly Journal of Medicine and Surgery*. There are articles by Potter on cholera infantum, a review of a treatise on "embryogeny." Editor Geddings reviews C F Burdach's "A Treatise on Physiology as an Experimental Science."

The stethoscope is now in use routinely, at least in chest cases in Baltimore. (Geddings' "Observation in the Pathology and Treatment of Asthma" gives the auscultatory findings in this disease).

The material is largely local in origin, the reviews of the modern literature live up to the promise, furnishing everything of practical importance. But this journal could not compete with the better known *American Journal of the Medical Sciences*, which was performing the same service better.

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The National Society for the Prevention of Blindness recommends a vision test requirement for all seeking hunting licenses to help reduce the number of hunting accidents.

A Methadone Maintenance Program in a Community General Hospital: A First Year's Experience

FRED R GOLDMAN ACSW

JOSEPH I BERMAN MD MPH

JOHN B IMBODEN MD

Mr Goldman is Administrator, Sinai Hospital Drug Dependency Program, Sinai Hospital of Baltimore Inc.

Dr Berman is Chief, Department of Community Medicine and Co-Director, Sinai Hospital Drug Dependency Program.

Dr Imboden is Chief, Department of Psychiatry and Co-Director, Sinai Hospital Drug Dependency Program.

Information and reprint requests to Mr Goldman at Belvedere and Greenspring, Baltimore Md 21215.

Introduction

This paper reviews the first year's experience of the Sinai Hospital Methadone Maintenance Program for the period Sept 28, 1970, to Sept 28, 1971. The report is divided into several parts: program origins, the hospital setting, the Methadone Maintenance Clinic, patient characteristics, summary, and discussion.

No attempt will be made specifically to discuss methadone as a treatment for opiate addiction. This subject has been extensively reviewed in recent reports.^{1,2}

Program Origins

The Methadone Maintenance Program at Sinai Hospital began as a true "grassroots" effort. Key individuals from the general community and the hospital staff became increasingly concerned about the rise in the number of opiate users and abusers in the City of Baltimore, and this concern led to a joining of efforts to establish a treatment program in the northwest area of Baltimore City. Treatment facilities in Northwest Baltimore and in adjacent Baltimore County in the late 1960s were essentially nonexistent, and only three methadone maintenance programs existed in the City at the time that the planning for the Sinai program began. These were Man Alive Inc, Project Adapt, and the Johns Hopkins Hospital Drug Abuse Program. Only about 1000 of the City's estimated 12,000 addicts were under treatment.

Attempts to secure funding for a methadone maintenance program were made in late 1968 and early 1969 to all levels of government, but no funds could be found. For this reason, members of the Associated Jewish Charities and Welfare Fund of Maryland were approached for assistance in developing the needed resources for

a program. Together with members of that agency, the concept of a drug treatment program for Northwest Baltimore, including a variety of services to opiate and nonopiate abusers, was developed.

The Associated Jewish Charities decided to support a two-year demonstration drug program, with a Methadone Maintenance Program located at Sinai Hospital representing the bulk of the financial input. Support was also promised from the United Fund of Central Maryland. No restrictions as to race, color, or creed were placed on the patients to be taken into the program in full accordance with Sinai Hospital's admission policy. Because of the urgency of the problem, Sinai agreed to provide space, pharmacy assistance, plus other technical assistance and support, at no cost. Application for an Investigational New Drug permit was made to and ultimately approved by the Food and Drug Administration, so that methadone could be used for maintenance purposes. On Sept 28, 1970, a 50-patient Methadone Maintenance Program for hard-core addicts opened. Because of the fear of inundation by patients wanting help, publicity was held to an absolute minimum.

Methadone Maintenance Clinic

The Methadone Maintenance Clinic is housed in a part of the Hospital Outpatient Department, an area with more than 60 clinics with over 50,000 patient visits per year. The methadone clinic is open from noon to 8:00 PM five days per week, and for two hours on Saturday and Sunday. Methadone, previously prepared in the hospital pharmacy, was dispensed during the first year, for a two-hour period from 5:00 to 7:00 PM seven days per week. Regular clinic examining rooms were used during the afternoons and evenings for medical evaluations and individual and group counseling. A side entrance provides easy access to the clinic and reasonable security.

Initially, the program personnel consisted of a half-time physician, one nurse-counselor, and one counselor. Later a program administrator joined the staff.

Program philosophy was that of temporary methadone maintenance, using techniques established earlier by Dole and Neiswander,³ and guidelines published by the FDA.⁴ It was hoped that at some point each patient would attempt detoxification from methadone maintenance although it was obvious that the exact time that this detoxification began would be dependent on a variety of factors.

Requirements for admission to the program were relatively simple: evidence of two years of opiate addiction, without any other major addiction problem or severe psychiatric difficulty. Parental permission was required for those 21 and under. All patients were informed, in accordance with FDA and hospital requirements, that methadone was being used experimentally and that data would be collected periodically for evaluation of the drug.

Patients were stabilized on dosages of methadone up to 140 mg/day, and were required to drink the methadone under direct observation in the clinic. No prescriptions were ever given to patients. Patients earned the privilege to receive take-home dosages (up to a maximum of three days off per week) by passing urines free of all drugs except methadone and by maintaining acceptable social behavior for several months. Urines were routinely collected, under observation, three times per week to detect use of other opiates, sedative hypnotics, and amphetamines.

All patients were assigned to counselors who worked with the patient individually and, in some cases, with additional group therapy. Counseling was directed at problems in daily living including job placement and family relations. Psychiatric back-up, available through the Department of Psychiatry, was used only infrequently.

Patients doing poorly (eg, continued illicit drug abuse, failure to maintain a job, dealing in drugs) were seen by the program physician, who also regulated methadone dosage and cared for routine medical problems. The decision to terminate a patient because of inability to modify behavior was made by the physician after joint staff discussion.

Patient Analysis

During the first year of operation, 512 applications to the clinic were made, the majority by telephone. Ninety-nine patients were actually accepted for treatment (see Table 1); 38% of the applicants did not appear for the initial appointment.

Table 1: Patient Applications to Sinai Methadone Clinic as of 9/28/71

Disposition	#	%
Accepted to program	99	19.3
Refused admission	337	65.8
Referred to constituent agency	5	1.0
In evaluation for program	8	1.6
Awaiting evaluation	63	12.2
Total	512	100.0

Nearly one third of the patients accepted were taken from Postal Zone 15 in which the hospital is located. Approximately 28% of the patients were taken from adjacent zones, and 39% from more distant zones surrounding the hospital is located. Approximately 28% of the patients were taken from adjacent zones, and months after the program opened, there has been a decided tendency for patients living in this area to join the program. Wherever possible, patients coming from long distances were referred to programs closer to their homes because of the need of daily visits.

Tables 2 and 3 contain a description of patients according to race, sex, and age. Four fifths of the total intake was composed of males. About 58% of that group was White, 42% Black. Among the females, about half were White, half Black.

Table 3 demonstrates that the largest single age group, accounting for nearly one half the total, was the 20-24 age range. Fully two thirds of the accepted patient population was accounted for by persons between the ages of 15 and 24.

Table 2: Race and Sex of Sinai Methadone Patients as of 9/28/71

Patient	#	%
White male	47	46.1
White female	11	10.8
Black male	34	33.3
Black female	10	9.8
Total	102*	100.0

* The discrepancy between this total and the totals in other tables is due to three patient readmissions.

Table 3: Age Distribution of Sinai Methadone Patients as of 9/28/71

Accepted in First Year		
Age	#	%
15-19	21	21.2
20-24	45	45.4
25-29	17	17.2
30+	16	16.2
Total	99	100.0

Table 4: Age of Initial Drug Experimentation for Sinai Methadone Patients Accepted in First Year

Age	#	%
10-14	33	33.3
15-19	46	46.4
20-24	17	17.2
25-29	2	2.0
30+	0	0.0
Unknown	1	1.0
Total	99	99.9*

* Rounding error accounts for the difference.

Table 4 shows the age of initial exposure to drugs of any type in our patient group. One third of our patients began using drugs between the ages of ten and 14. Almost one half began between the ages of 15 and 19. In all, 80% of the patients began their drug experiences in the age range 10 to 19, although it is to be emphasized that these were all drugs of all types. The dropout rate does not appear to be related to the age at which our patients began using drugs.

Progress of all the patients on the program was continually monitored with respect to such factors as number of positive urines, attendance at counseling sessions, and attendance in the methadone clinic for medication. Of nearly 11,000 appointments for medication, over 97% were kept. Similarly, over 90% of the urines tested for traces of narcotics once the patient was accepted on the program (over 4000 tested) were negative. Eighty percent of patient counseling appointments (out of about 2400 scheduled) were kept over the year. Those patients who were unable to comply with clinic demands were dropped from the program.

Two indicators of patient success are illustrated in Tables 5 and 6. Table 5 reports the employment status for patients before they joined the program and since being on it. (This includes only the 55 patients active as of Sept 28, 1971.) With participation in the program the percentage of unemployed patients is more than halved, while that for employed patients is increased by over one third.

The foregoing statistics are based on the inclusion of housewife and student in the "employed" category. Since beginning the program, 16 of the 55 patients have become employed, while only four of those initially employed are no longer working. It is evident that at least for the time in which patients are active in the program they tend to make an appropriate social adjustment in terms of employment.

Arrest records prior to and since program

Table 5: Employment Status of Patients on Sinai Methadone Program As of 9/28/71

Status	#	%
When Patient Entered Program		
Employed*	25	45.4
Housewife or student	10	18.2
Unemployed	20	36.4
Total	55	100.0
Present Status		
Employed*	40	72.7
Housewife or student	7	12.7
Unemployed	8	14.5
Total	55	99.9**

Employed when entering program but unemployed at present 4

* Median numbers of hours worked, prior and current = 40.

** Rounding error accounts for the difference.

Table 6: Arrest Status of Patients on Sinai Methadone Program As of 9/28/71

	# of Arrests	# of Persons
6-month period prior to program	23	18
Period since admission to program*	11	9
Patients with prior arrests	5	4
Patients with no prior arrests	6	5

* Time period varies from 1 week to 11 months; Med = 6 months.

participation are reported in Table 6. The data show that nine persons were arrested after coming on the program, as compared to 18 persons being arrested in the six-month period prior to beginning the program. Of the nine, five persons had no prior arrests, and only four of the 18 were rearrested. Fourteen patients who had previous arrests were not arrested after participating in the program. These data suggest that program enrollment is correlated with decrease in criminal activity but continued observations are needed before firm conclusions on this point can be reached.

Table 7: Sinai Methadone Clinic Patient Movement (9/28/70 - 9/28/71)

Patients admitted to clinic during year		99
Patients discharged during year		
Successfully detoxified	2	
Detoxification unsuccessful	5	
Detoxification not attempted	37	
Total Discharged		44
Patients active as of 9-28-71		
Detoxification in progress	6	
On maintenance therapy	49	
Total Active		55

Success with detoxification has been modest as illustrated in Table 7. Only two patients of

the 99 admitted to the clinic have been completely detoxified and are maintaining themselves in a productive drug-free manner. These two individuals are assisting in program counseling. Five others attempted detoxification and were unsuccessful. Thirty-seven patients left the program without attempting detoxification.

Discussion, Summary

In September 1970, after several months of planning and preparation, Sinai Hospital of Baltimore Inc opened its clinic for opiate addicts, employing methadone maintenance. Begun as a privately financed demonstration project, the Program has become funded by the State of Maryland Drug Abuse Administration. The program has continued from its beginning to operate with a minimum of difficulties within the Outpatient Department of Sinai Hospital.

Ninety-nine persons were accepted in the program within the year beginning Sept 28, 1970 with 44 being dropped during this time period. Those patients who have remained on the Program have done so with a minimum of "dirty urines" and missed appointments. The employment or student status of patients after entering the Program was significantly increased while overall criminal activity of patients measured by arrests was reduced by one half after persons entered the clinic. Only two of the patients who have been detoxified from methadone have been able to remain completely drug free.

Compared with the results of six ambulatory methadone maintenance programs in New York in 1970, the Sinai Program shows a higher percentage of patients discharged from its roster.⁵ Of 1952 patients in treatment in the New York programs as of Oct 31, 1970, the percentage of total discharges was 12%.

This same study shows a higher rate of discharge among men less than 30 years of age than among men 30 years of age or over. Therefore, the fact that persons under 30 make up only 25% of the 2835 men in treatment in New York City as of June 30, 1970 may be related to the lower percentage of discharges among both inpatients and outpatients.

The relative youthfulness of our patients, 84% of whom are under 30, might suggest an explanation for the higher dropout rate from the Sinai Program. However, the experience in the first year of Sinai contradicts the experience of other programs. While absolute numbers demonstrate that a larger number of younger

persons have dropped out than older persons (over 30), when comparing the percentage of dropouts by age, those over 30 have a higher dropout rate than those between the ages of 15 to 19 and 25 to 29, only slightly lower than those between ages of 20 to 24. Therefore, age does not appear to be a primary or sole factor in predicting success in the Sinai Program.

Also important is the higher percentage of black persons dropped from the program than white persons. While many factors probably play a role here, we have noted that black patients tend to have abused heroin, while whites tend to have abused illicit methadone prior to acceptance in the program.

With an increased grant provided by the Drug Abuse Administration, Sinai is expanding its services to opioid abusers by increasing its capacity from 55 to 100 patients. In addition to the methadone maintenance program, a methadone detoxification component and abstinence component have been added to make the total program more comprehensive in scope.

The experience of the Sinai Hospital Drug Dependency Program has demonstrated the feasibility of operating a clinic for opiate abusers within a hospital setting.

The general hospital has an important role to play in the treatment of drug addiction. It is our hope that the experience of the Sinai Hospital Drug Dependency Program will stimulate other hospitals to extend services to drug abusers in their communities.

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RETROPERITONEAL FIBROSIS DUE TO OBSOLETE SARCOIDOSIS

Report of a Case with Special Reference to Etiology

MONTE A HERMAN MD

Information and reprint requests to Dr Herman at 1401 Blair Mill Rd, Silver Spring Md 20910.

Introduction

In 1948 Ormond¹ reported the first two cases of bilateral ureteral obstruction due to a retroperitoneal inflammatory process. Since that time enough additional case reports have appeared to clearly define this entity in its clinical presentation and course, as well as its therapeutic approach. Most observers no longer have significant difficulty with the diagnostic features nor with the plan of therapy. The etiological considerations, however, of this disease are still quite unclear and account for much of the interest devoted to this condition. Accordingly, this report will cite a case, review briefly the salient points of the illness, and stress etiological factors with particular reference to the case reported.

Case Report

The patient, a 36-year-old black male, was admitted to the hospital on Nov 13, 1961 complaining of increasing shortness of breath, right-sided chest pain, severe headaches, and swelling of the legs of one week's duration.

In 1952, while in the Army, a myocarditis, as reflected by ST electrocardiographic changes, was suspected during a hospitalization for pneumonia. A digitalis preparation was necessary at that time. The blood pressure was 140/60, and pyuria was noted. In 1953 the patient was admitted to another hospital with a presumptive diagnosis of mediastinal tuberculous lymph nodes. A cervical node biopsy was reported to have confirmed that diagnosis, and antituberculous therapy was instituted. The blood pressure was 140/110, and cardiomegaly was present. An intravenous pyelogram showed only a horseshoe kidney. In 1958 he was again hospitalized with marked exertional dyspnea and ankle edema. His blood pressure was 190/130, hematocrit 45%, urine specific gravity 1.022, BUN 9 mg%, LE prep negative, and PSP 10% excretion in 15 minutes and 85% in two hours. Another intravenous pyelogram once again showed a horseshoe kidney and blunting of the calyceal system on the right.

Retrograde examination confirmed these find-

ings. Antituberculous therapy was once more begun due to enlarged left hilar lymph nodes. In June 1959 Reserpine 0.25 mg and Diuril 500 mg each twice daily were begun. On May 19, 1960 the patient experienced a convulsion. His blood pressure was 170/130, but his fundi were within normal limits. A Regitine test was normal. He was next seen on Nov 3, 1961 with complaints of diarrhea and headache of four days' duration. Blood pressure was 240/150, the heart was enlarged, fundi revealed marked venous compression and exudates, and intravenous pyelogram did not visualize. Sputums collected for AFB were negative throughout the patient's several hospital admissions.

The pertinent family history indicated his father to be living and well at age 65 but to have epilepsy. His mother, who was 61, had hypertensive cardiovascular disease. In the 1940s a cousin had had tuberculosis.

The patient smoked as much as ten cigarettes per day and drank two or three beers per day and one fifth of whiskey on weekends.

When he was hospitalized for the last time on Nov 13, 1961, his blood pressure was 200/145, the neck veins were distended, fundi showed bilateral exudates, the heart was enlarged with a loud apical systolic murmur and accentuation of the aortic second sound, the liver was enlarged and tender, and the lower extremities and sacrum were markedly edematous.

Chest X-rays showed bilateral pleural densities, HCT 20%, BUN 96 mg%, Na 136, K 3.3, CO₂ 19, albumin 3.5 mg%, globulin 2.0 mg%, SGOT 21, SGPT 10, FBS 110 mg%, and urine specific gravity 1.009, protein 3 plus, and 0-3 RBC on microscopic examination. He was digitalized with digitoxin and placed on a sodium restricted diet. Four days later urinalysis revealed numerous WBCs and RBCs, and a stool was strongly positive for occult blood. Sigmoidoscopy showed no evidence of bleeding or ulceration. An intermediate PPD was negative. Seven days after admission the BUN was 144 mg% and on the following day 168 mg%. Fourteen days after admission the BUN reached 207 mg%, and uremic frost was noted. The patient expired on the following day.

At autopsy both pleural cavities were completely obliterated by dense fibrous adhesions. Similar fibrous adhesions obliterated the pericardial cavity. There was widening and marked thickening of the mediastinal connective tissue in the vicinity of the aortic arch and tracheal bifurcation. The dense fibrous tissue appeared greatest at the site of the anatomic location of lymph nodes, which appeared obliterated by this fibrous tissue. Around the superior vena cava the fibrous tissue was most dense, but it did not appear to constrict that vessel. In the hilar areas of the lungs there was a moderate increase in the connective tissue in which matted lymph nodes were found.

Dense fibrous tissue lay in the hilar region

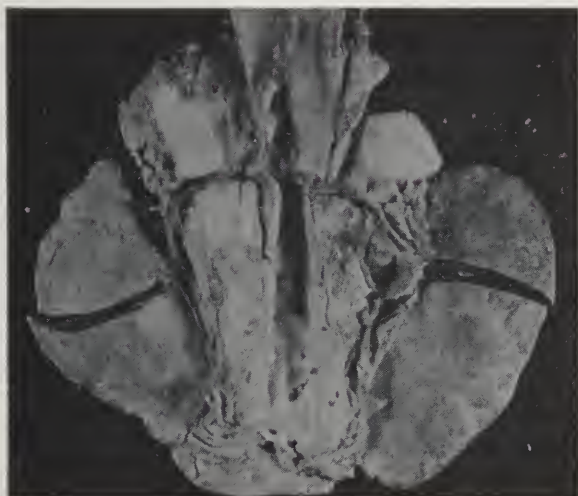


Fig 1: Note the thick fibrotic tissue surrounding the aorta.

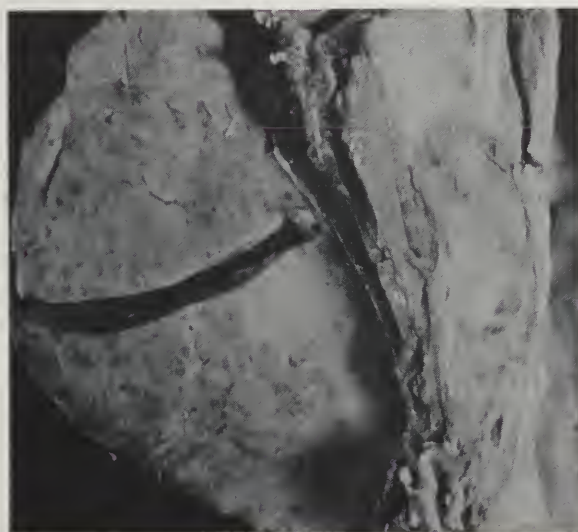


Fig 2: A closer view of the thick peri-aortic fibrotic tissue.

of each kidney and surrounded the aorta in the renal area (Figs 1 and 2). This para-aortic fibrous tissue appeared most thick in the vicinity of the origins of the renal arteries, fading off along the aorta cephalad and caudally. Bound down discretely in this mass of fibrous tissue were a number of enlarged lymph nodes. A mild hydronephrosis was present on the right side.

Microscopic examination revealed a dense diffuse and nodular hyaline fibrosis of the periarterial, perivenous, and peribronchial connective tissues. This hyalinosis was greatest and most dense in lymph nodes and extended out into thickened connective tissues of the pleura and intersegmental fissures. Occasionally the hyaline connective tissues encroached on the walls of pulmonary arteries and veins, replacing elastic fibers in such areas.

In the vicinity of the renal hila dense fibrous tissue of a nodular and diffuse type extended from peri-renal lymph nodes into the adventitial areas of renal arteries, veins, and lymphatics.

In the lymph nodes in all areas there were changes of obsolete sarcoidosis varying from occasional small collections of hyaline material to dense nodular hyaline changes (Fig 3) with the presence of occasional nonnecrotic giant cell granulomas.

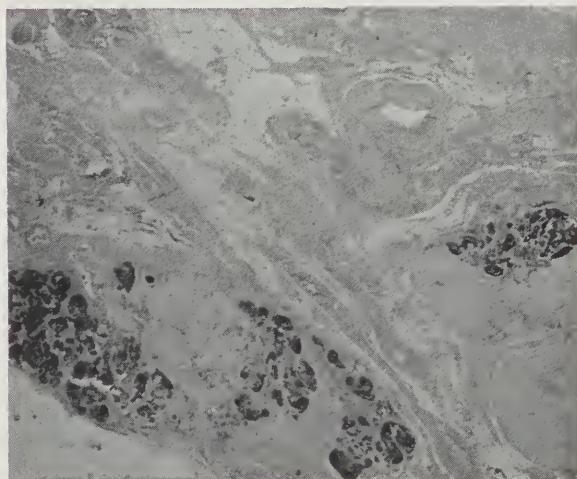


Fig 3: Lymph node showing replacement of normal architecture by whorls of hyaline material. Occasional nonnecrotic giant cell granulomas may be seen.

Discussion

Idiopathic retroperitoneal fibrosis is a rare disease in which the tissues of the retroperitoneum, or mediastinum in the case of mediastinal fibrosis, are infiltrated by aggregations of dense fibrous tissue containing a variable inflammatory infiltrate. Since the fibrous tissue usually makes

its presence known by surrounding and constricting the tubular structures of the retroperitoneum (or mediastinum), the disease usually comes to the attention of the urologist when the ureters are sufficiently constricted so as to be the source of clinical manifestations. However, it is not primarily a urological condition but rather a generalized disease as has been illustrated by the case cited and will be further emphasized by the following clinical and etiological review.

Clinically the disease presents with very nonspecific findings so that early in its course diagnosis is difficult. The usual afflicted male has often experienced months of ill health manifested by malaise, anorexia, nausea, vomiting, weight loss, anemia, and low-grade fever. The most characteristic symptom is a nagging pain in the back, not necessarily in the renal areas, which may radiate to the groins, the testicles, or down the inner aspect of the thighs. Physical examination is most often unrewarding in that only rarely is there a palpable abdominal mass, and the temperature is usually not remarkable.² The only constantly abnormal laboratory value is a markedly elevated erythrocyte sedimentation rate.³ Erythrocytes and leukocytes are frequently found in the urine.⁴

The structure which is the last to be enveloped by the enlarging mass of retroperitoneal fibrotic tissue, and the one that invariably gives rise to symptoms when involved is the ureter. Gradual obstruction of the ureter causes increasing hydronephrosis and progresses toward complete destruction of the kidney. Uremia results if the condition is bilateral. Closure of the ureters often causes anuria, which brings the patient to the urologist.

Diagnosis is most importantly made by radiological investigation of the urinary tract. Intravenous pyelography may show unilateral or bilateral hydronephrosis or unilateral absence of function. The most important findings are dilatation of the upper ureter and pelvis with narrowing or obliteration of the midureter and with deviation of that part of the ureter medially, as if contraction of the fibrous tissue had taken place after the ureter had been enveloped. The latter radiographic finding is the most important roentgenologic sign.²

Ureteral catheterization and retrograde pyelography can usually be accomplished with ease, despite the presence of the periureteral fibrotic lesion.⁵ This study confirms the findings on intravenous pyelogram.

The diagnosis finally must be confirmed by biopsy of the mass. Grossly a firm gray plaque

two to six cm thick is seen extending from the hila of the kidneys above, laterally to a line running one cm on the lateral side of the ureters, and to the pelvic brim below.⁶ These boundaries correspond to those of the renal fascial compartments.

Microscopically the pattern seen is one of various stages of development of a nonspecific, nonsuppurative inflammation in fibro-fatty tissue. The picture varies from a subacute cellular process with lymphocytes and eosinophils to completely hyalinized fibrosis with occasional calcification.⁷

The principle of treatment of this condition is relief of ureteral obstruction while preserving renal tissue. To this end ureterolysis with intraperitoneal ureteral transplantation is the mainstay of therapy.⁷ Steroids, antibiotics, and X-ray therapy have been utilized but have not yielded consistent results.

Etiological theories of retroperitoneal fibrosis are multiple, indicating that no single theory explains all cases. Many etiological agents have been put forward to account for its pathogenesis. This report emphasizes one of the most infrequently reported causes.

One view postulates that fibrin is deposited in the renal fascial space and flows about the structures in that compartment like a liquid which then sets to a firm gel.⁶ Fibrin may result from bleeding from small vessels or from microscopic leaks of the aorta or iliac arteries.⁸ There then follows collagenous replacement of the fibrin.

Methysergide may perhaps be related to this condition through this mechanism. This drug, useful in the treatment of migraine, may cause spasm of the aorta or possibly its vasa vasorum leading to damage of the aortic wall with resultant leakage of blood through that defect.⁹

Since, however, this explanation cannot adequately clarify the pathogenesis in all cases, numerous other factors have been invoked as causal agents. An infectious source at some distance transported through the lymphatics or vascular system has been suggested by Ormond.² Shaheen and Johnston¹⁰ designate infection of the gonads spreading via gonadal veins or lymphatics as a possible cause. This inflammation then envelops the great vessels and other retroperitoneal structures.

Infection must naturally lead to the lymphatic system. The para-aortic lymph nodes, which drain the bowel, are adjacent to the aorta and thus lie in this retroperitoneal space. Thus any inflammatory disease of the bowel could reach

this space by way of the lymphatics, and indeed this fibrotic process has been reported with regional enteritis, ulcerative colitis, diverticulitis, and appendicitis.¹¹ It is known that retroperitoneal infections may begin quietly, be prolonged in duration, and produce minimal or no symptoms.^{12,13} Thus retroperitonitis which remains subclinical for a variable period may develop, and in the course of time fibrosis may follow.¹⁴

Lymphadenopathy due to sarcoidosis has been reported as a possible precursor of retroperitoneal fibrosis.^{2,15} The characteristic lesion of sarcoid may be replaced by fibrosis, hyalinization, or by both. In spite of diagnosis of tuberculosis and therapy with antituberculous drugs in the author's case, it is probable that this case was one of sarcoidosis from the onset. This is especially so since all sputa for tubercle bacilli were negative, and tuberculin skin test was likewise negative. Further the lymph nodes at the time of postmortem examination failed to show any caseation necrosis. The mediastinal lymphadenopathy and surrounding fibrosis along with the retroperitoneal lymphadenopathy and fibrosis seem to indicate that the fibrosis was related to the lymph nodes and the lymph nodes were related to sarcoidosis. This latter entity is then reemphasized as a possible etiologic factor in retroperitoneal fibrosis.

Other reported causes of this process include urinary leakage from the upper urinary tract,¹⁶ Weber-Christian disease,¹⁷ various malignant tumors,¹⁸ Hodgkin's disease,¹⁸ lymphoma,¹⁹ and collagen diseases.^{20,21} Ormond²² now feels that this process is an immunologic hypersensitivity disorder provoked by drugs acting as haptens and places it in the collagen disorders.

Summary

A case of retroperitoneal fibrosis due to obsolete sarcoidosis is presented. The usual case occurs in a middle-aged male who presents with backache. As the fibrotic process envelops the retroperitoneal structures, oliguria or anuria may result. Intravenous pyelography reveals medial deviation of a hydronephrotic ureter, and biopsy of the fibrotic mass confirms the diagnosis. Ureterolysis is the accepted form of therapy. The cause has been attributed to bleeding, infection, an auto-immune process, and other mechanisms. It is probable that retroperitoneal fibrosis is caused by a number of different agents among which is sarcoidosis.

References

A complete list of the 22 references used with this article may be secured from the author.

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MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND 175th ANNUAL MEETING

APRIL 25, 26, 27, 1973
Baltimore Civic Center

* * * * *

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175th ANNUAL MEETING
MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND
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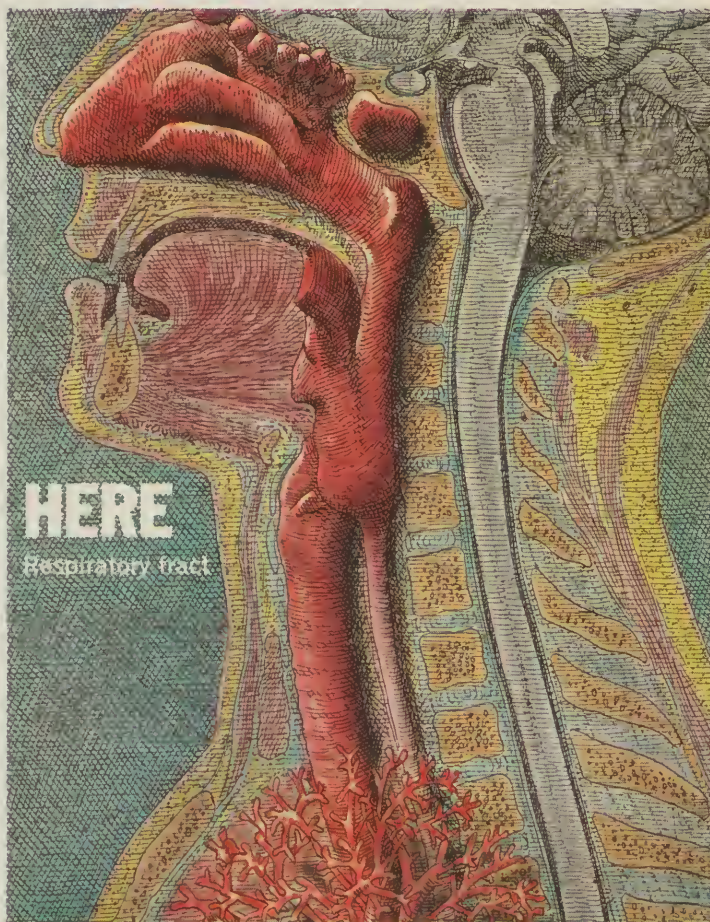


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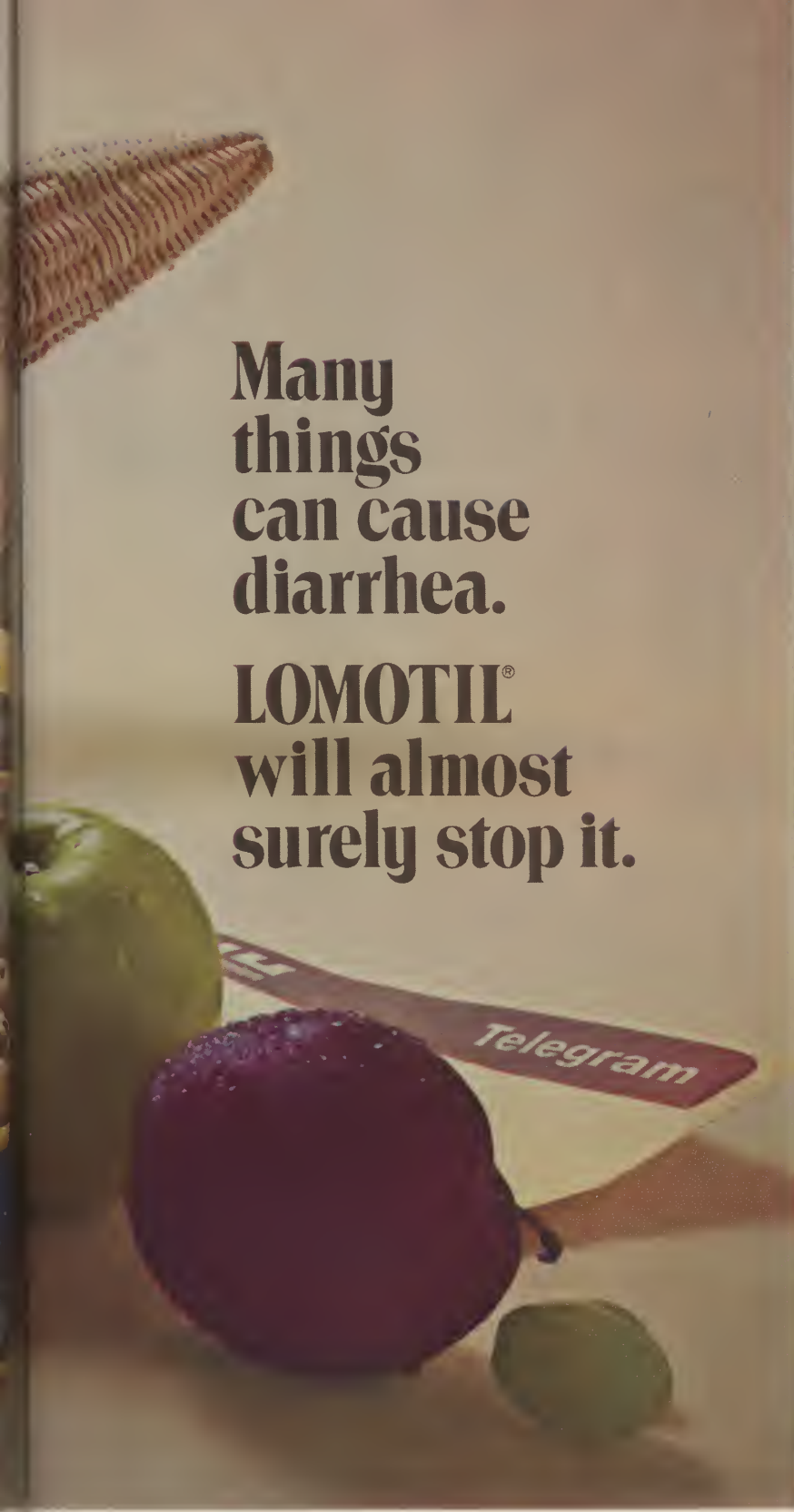
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NEONATAL SEPSIS DUE TO CLOSTRIDIUM PERFRINGENS

STUART H WALKER MD
EMMANUEL I MACARAEG MD

Dr Walker is Professor of Pediatrics, University of Maryland, Baltimore. Dr Macaraeg is Resident in Pediatrics, Mercy Hospital, Baltimore.

From the Department of Pediatrics, Mercy Hospital, 301 St Paul Place, Baltimore Md 21202; information and reprint requests should be directed there.

Introduction

Clostridium perfringens is an ubiquitous commensal organism which infrequently causes myonecrosis (gas gangrene), sepsis with or without hemolytic anemia, necrotic enteritis, and/or septic abortion. Sepsis, which usually follows intraabdominal surgery, abortion, wound infection, or malignancy is associated with a high mortality.^{1,2} We report the successful antibiotic treatment of a one-week-old infant with sepsis due to *Clostridium perfringens*, Type A.

Case Report

A 3200-gm infant was delivered without incident by an apparently normal 23-year-old Negro mother at an estimated gestational age of 36 weeks. The duration of labor was four hours and the membranes ruptured spontaneously shortly before delivery. Except for slight jaundice the infant was normal at the age of three days when discharged from the hospital.

At the age of seven days the mother noted that the infant was lethargic, seemed febrile, and sucked poorly. Jaundice became evident to the mother for the first time on the ninth day of life.

The infant was hospitalized on the tenth day of life at which time he weighed 2750 gm. The temperature was 38.2 C, the pulse was 120, and the respiratory rate was 30. The anterior fontanelle was markedly depressed, the neck was slightly stiff, the liver was palpable 3.0 cm below the costal margin and the extremities were hypertonic. The umbilical stump was moist and foul-smelling but there was no evident discharge or surrounding inflammation.

The white-cell count was 21,700 with 25% segmented neutrophils and 16% band forms. The hematocrit was 48%. The platelet count was 725,000 and the reticulocyte count 0.5%. The total bilirubin was 28.5 mg, the direct bilirubin less than 5 mg, the urea nitrogen 30 mg and the glucose 170 mg/100 ml. The sodium was 148 mEq, the chloride 121 mEq, the potassium 6.4 mEq and the carbon dioxide 4.4 mEq/

liter. A lumbar puncture revealed slightly cloudy cerebrospinal fluid. The white-cell count was 88 with 45% neutrophils; the protein was 610 mg and the glucose 94 mg/100 ml. No organisms were seen on smear.

Intravenous fluid therapy was commenced and after cultures were obtained, penicillin G 120,000 u/Kg/day, and gentamicin 6 mg/Kg/day, were administered intravenously. The total bilirubin increased to 31 mg/100 ml, of which 9.3 mg was direct reacting, and the hematocrit decreased to 35% within 12 hours after admission. The reticulocyte count was 0.5%. The blood glucose increased to 916 mg/100 ml and the serum sodium decreased to 128 mEq/liter approximately eight hours after admission. Regular insulin, three units, was administered intravenously, and the concentrations of potassium and sodium in the intravenous fluids were increased.

The hematocrit stabilized after approximately 18 hours and on the second hospital day packed cell transfusion restored it to 44%. The infant appeared well hydrated but he remained lethargic and sucked poorly. The isolation of *Clostridium perfringens*, Type A from a blood culture and from a culture of umbilical stump secretions obtained at the time of admission was reported. The typing of this organism was subsequently confirmed by Dr V R Dowell Jr at the National Communicable Disease Center. No organisms were isolated by aerobic or anaerobic culture of the cerebrospinal fluid.

The apparent metabolic acidosis was rapidly restored to normal concomitant with decrease in the blood urea nitrogen. The blood glucose decreased to normal after 48 hours without the administration of additional insulin. The total serum bilirubin gradually decreased to 14.4 mg/100 ml on the fourth hospital day and to 2.4 mg/100 ml on the 22nd hospital day. A lumbar puncture on the tenth hospital day revealed nine lymphocytes per cmm. The protein concentration was 181 mg and the glucose concentration 61 mg/100 ml. No abnormalities were detected by a brain scan and a liver scan. Several blood cultures and cerebrospinal fluid cultures obtained after the initiation of therapy revealed no bacterial growth. Two months after discharge at approximately three months of age the patient's head circumference was 37 cm, his weight was 4050 gm and he was feeding poorly. A brain scan and an electroencephalogram revealed no abnormalities.

Discussion

Clostridium perfringens, an inhabitant of the normal human intestine, is present in the vaginal flora of between 10% and 27% of normal women.³ In this hospital cultures obtained from inflamed umbilical stumps in otherwise well newborns grow this organism several times each year. Surprisingly, however, only two instances of neonatal sepsis have been reported in the recent English literature. One infant died of *Clostridium perfringens* sepsis after an exchange transfusion¹ and the other developed fulminant hemolysis and died 19 hours after the partial excision of an abdominal neuroblastoma.⁴

In addition to the evidence of rapidly progressive hemolysis, typical of clostridial sepsis, this infant demonstrated a moist, foul-smelling umbilical stump consistent with localized clostridial infection. Marked metabolic acidosis, hyperkalemia, and azotemia, as noted in this patient, were considered characteristic of the adults with clostridial sepsis reviewed by Isenberg.¹ Marked hyperglycemia has not been previously noted. Involvement of the central nervous system was evidenced by the cerebrospinal fluid pleocytosis and protein elevation and by the residual defects in brain growth and development noted at age three months.

Meningitis due to *Clostridium perfringens* is not rare although it has not been reported in the neonate. Although it commonly develops consequent to penetrating wounds of the skull,⁵ it has been reported in association with sepsis following intraabdominal⁶ and prostatic⁷ surgery. Brain abscess may occur and meningitis may be fulminant leading to death in less than 24 hours⁷ or indolent with recovery after many weeks of therapy.⁶

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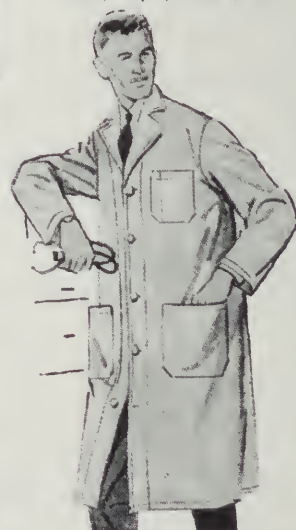
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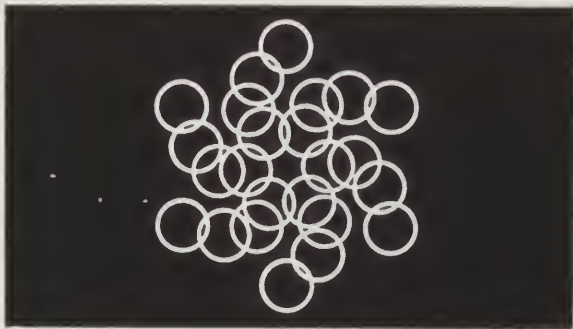
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TREATMENT OF ALCOHOLISM — PART 1

Reprinted from "First Special Report to the US Congress on Alcohol and Health from the Secretary of Health Education and Welfare," December 1971, DHEW Publication (HSM) 72-9099.

The causes of alcoholism are so many and appear in such differing constellations from person to person that one cannot consider treating alcoholism as if it were a single illness with an identifiable and specific etiology, a known course, and a proven response to a particular chemical agent or medical treatment. Alcoholism is the result of complex and interacting factors. About the only characteristic shared by most of the alcoholic population is some pattern of repeated alcohol abuse that acts as a form of "self-treatment" for the sufferer.

The variety of people afflicted with alcoholism is probably as varied as humanity itself, and a variety of treatment techniques have been developed and, hopefully, are waiting to be developed for this field. Although each technique has its partisans, the critical research has not been done to demonstrate convincingly which approach works best with which specific person.

There is some general misunderstanding about the pain experienced by the alcoholic person. Sometimes we forget this, however, and view the alcoholic person only as a fun-loving, irresponsible, and childish person who is given over to the immediate gratification of every impulse. As a matter of fact, such a being exists within every one of us. Yet on reaching maturity we have to deny this part of ourselves. Thus when it looks as though the alcoholic person is not playing the game of adulthood fairly, we get angry with him and attempt to teach him a lesson or to give him the "good-old-kick-in-the-pants" treatment. Sometimes this creates an ambivalence in those who treat the alcoholic patient—an ambivalence based on an overt and conscious wish to help the alcoholic patient, and

a covert and unconscious wish to punish him. These conflicting feelings may distort a treatment program.

Pain of Alcoholism

The pain the alcoholic person feels is the pain of self-loathing and humiliation . . . from loss of the respect of his family and friends . . . from growing isolation and loneliness . . . from the awareness that he is throwing away much of his unique and creative self and gradually destroying his body and soul. He doesn't usually mean to get drunk, really drunk—he just wants to take the value from alcohol. Getting drunk, really drunk as only an alcoholic person becomes, is a nightmare of lost memories, retching, vertigo, the shakes, and a profound melancholy of regret. Sometimes it becomes a living nightmare of terrifying visions, screaming accusatory voices, and convulsions.

Who would seek such experiences knowingly? From the intrapsychic viewpoint, heavy drinking is a form of adaptation or adaptive repair that has gotten out of control. Maladaptive symptoms are developed and maintained tenaciously because they are useful. For example, phobia is developed as a way to hide a serious neurotic fear behind some foolish fear, such as fear of heights or of closed spaces or of water. The foolishly feared thing is then avoided so that awareness of the underlying neurotic fear can be avoided. In addition, once stuck with such a problem-solving technique, the unhealthy coping mechanism can be used for secondary advantages such as avoiding responsibilities.

Value of Alcoholism

Alcohol has many such advantages. Indeed, it is the ubiquitous and quick problem-solving potential of this substance which is our major problem. In small doses for social drinkers, it gives a pleasantly softening and mood-elevating effect

that facilitates social interaction. A slight "buzz" is experienced as pleasurable. For the alcoholic person, however, a "big bust" has become a necessity for survival. It may provide euphoria to relieve apathy and sadness, a reduction of apprehension when more and more of life seems too stressful, or oblivion to blot out loneliness and disappointment. For some, it may provide a deliciously prolonged state of self-pity and destruction with which to punish someone.

More attention needs to be directed to the "value" of alcohol in helping the alcoholic individual cope—albeit in a sick way—with some of his deeply hurting problems. Therein lies the dilemma: The devastating effects of alcoholism are so obvious that we are bewildered by patients apparently evading or frustrating the best treatment efforts. But when heavy drinking is seen as an adaptive phenomenon, we are not so perplexed that people can actually treat themselves this way. This view opens up therapeutic opportunities. But it also brings a humble sense of respect for the symptom—alcoholism—and the knowledge that the solution will not be simple or easy. A few lectures on the evil effects of alcohol will not suffice, nor will increasing life's pain by punishment. Having accepted the reality of alcoholism as a chronic and often recurring sickness, one becomes more tolerant of relapses—the so-called "slips" by the patient and, at the same time, more optimistic about the long-range benefits of treatment.

General Systems Theory

A general systems theory approach can help to clarify the complexities of alcoholism. In the field of human actions, the general systems theory holds that behavior is composed of several layers of action and reaction, with each layer related to other layers that are more or less complex . . . or above or below it . . . in a systems hierarchy. Thus we cannot treat disordered behavior by assigning ultimate cause to one system, and then treating that system. Rather, multiple interacting systems must be taken into account.

Unfortunately, the systems approach precludes any easy answer. But the process of searching for answers is the "childhood" of any science and may be the forerunner of successful solutions.

The systems to be reviewed for therapeutic opportunities in the field of alcoholism are:

- Biological
 - Biochemical-cellular
 - Organ-body
- Intrapsychic
- Interpersonal

- Social
 - Small group
 - Large group
- Society

Biological

Biochemical-Cellular

The ill effects of alcohol on the body rather than the basic phenomenon of alcoholism itself have been of greatest interest to medical investigators and physicians, possibly because they feel more at home in this field. Some physicians confuse the treatment of alcohol intoxication with the treatment of alcoholism; nonmedical people are as much in error by thinking that the treatment of intoxication is not important in the treatment of alcoholism itself. Nevertheless detoxification, which is actually only the treatment of acute medical symptoms, is a vital first step in helping alcoholic individuals.

Treatment

Much is known today about the metabolism of alcohol and its pharmacological, metabolic, physiological, and biochemical effects on the human body. Improved detoxification processes have reduced the mortality and morbidity rate of severe intoxication and postintoxication states. The usual procedure is to use anticonvulsant drugs and sedative compounds to prevent seizures and delirium tremens during the period when alcohol-withdrawal symptoms are manifest. High-potency vitamins and general supportive care are also standard components of treatment at this stage.

Patients must be examined carefully to detect possible head injuries, tuberculosis, the development of pneumonia or other infection, or metabolic or electrolyte disorders. Sound sleep is sought with compounds that increase dream sleep since a deficit in dream sleep during and immediately following intoxication may be a factor in acute agitation, hallucinosis, or delirium tremens.

For many years, a medical axiom held that alcoholic patients are dehydrated. The patients were therefore treated with large amounts of intravenous fluids. Recent research has demonstrated that a rising blood alcohol concentration does indeed lead to dehydration. But if there is no diarrhea, vomiting, or unusual degree of perspiration, a drop or flattening curve of blood alcohol actually leads to overhydration. Thus, fluids are now given orally in many small drinks according to the patient's need to slake his thirst.

Ending the after-pains of intoxication more quickly has long been a goal of everyone who

ever got drunk. Many home remedies exist; none are effective. Administration of fructose sometimes speeds the metabolism of alcohol. But the central nervous system disorders and metabolic symptoms of acute postintoxication states may require a week or more—long after the alcohol has disappeared from the body—for complete physiological recovery.

Hospitals that accept alcoholic patients for detoxification are reducing both illness and death following acute alcoholic episodes. Despite positions taken by the American Medical Association and the American Hospital Association, however, some hospitals and physicians still avoid the responsibility for detoxification, and health insurance is often inadequate to cover its costs.

Organ-Body

Long, excessive use of alcohol has deleterious effects on the various organ systems such as the heart, pancreas, liver, peripheral nerves, brain, and body cells in general. Alcoholic hepatitis is now thought to be the precursor of cirrhosis. Acute heart failure in alcoholism has a very poor prognosis if the individual continues to drink.

The general social and physical deterioration of the alcoholic person finally results in the "skid row" bum caricature. Only a small minority of alcoholic individuals ever reach this level. Because of their utter helplessness and visibility, however, large amounts of money have been spent in their incarceration and arrest, while little treatment effort has been expended in their service. While the future of these forlorn people is not bright, their further deterioration might be halted by setting up long-term facilities that offer roofs and food and people who care, as well as relief from loneliness, to these unfortunate individuals without homes.

Treatment

For the great majority of alcoholic persons whose fate is by no means sealed, prompt and continued medical supervision is essential. Cessation of drinking and nutritional rehabilitation are the first order of treatment. Those who have suffered injuries to the central nervous system may need organ retraining to help compensate for irreversible damage. Failure to provide adequate medical care may result in premature death in many individuals, possibly by an average of ten to 12 years.

Intrapsychic

Many professionals treating persons with alcoholism base their techniques on the assumption that the disorder is a result of emotional

or unconsciously motivated factors. This assumption is controversial. Since intrapsychic factors are studied by inference and other indirect means, hard confirming information on the validity of this theory is difficult to collect. The view that alcoholism is an intrapsychic disorder is involved in the same debates as those surrounding the typology of emotional and mental disorders, and is subject to the same degree of criticism by many persons who object to seeing it thus classified.

Treatment

At this time, well thought-out and conclusive studies on the effects of various psychological treatment techniques are lacking, equivocal, or contradictory. The poor design of follow-up studies is discouraging, making it difficult to practice effective matching of patients and techniques.

Putting aside parochial arguments among psycho-therapeutic schools, however, most therapists agree that a vital part of any treatment program is the opportunity offered the alcoholic individual generally appears to be lonely and guilt-ridden. Beneath a facade of conviviality, he yearns for a trusting and nonjudgmental helping person upon whom to become dependent. This dependency is often accompanied by such distrust from earlier disappointments in life that the alcoholic person must challenge any new-found helper to see if this caregiver will be found wanting—like others who came before.

Individual therapy is the preferred mode of therapy for some people. But the course of individual treatment is often rocky and fraught with peril to the therapeutic alliance. For example, the alcoholic patient's repeated testing of the relationship is often so intense and continuous, it may result in fulfillment of the patient's fear and in reinforcing his view that no one can help. Another way of explaining this interaction is gleaned from the transactional analysis viewpoint that sees the alcoholic person engaged in a game or series of manipulations to accomplish his goal of making human contact. For the alcoholic patient to recover, the therapist must be a better game-player and be able to block destructive moves.

Psychotherapists do not agree whether total abstinence is an absolutely necessary goal and the only measure of success in the treatment of alcoholism. The abstinent alcoholic patient may present so many other disabilities that just giving up drinking may be an inadequate criterion for recovery. Abstinence has long been deemed the first essential step in psychological rehabilitation, but opinions keep appearing to suggest that some alcoholic persons can become normal

drinkers while, at the same time, increasing their psychological and interpersonal health in other areas. This viewpoint disturbs many therapists who fear that each alcoholic patient will see himself as the exception who can become a controlled drinker.

Who is qualified to treat the alcoholic patient? Some feel that an alcoholic person who has recovered from the illness is best qualified since he has a deep, personal understanding of the problem. Members of many professional disciplines disagree with this viewpoint. They agree that the recovered alcoholic person may have an initial advantage in establishing rapport, but fear that the depth of his understanding will be limited by the blind spots and prejudices of his own battle with the disorder.

This controversy is less partisan today than formerly. In our guild partisanship, we must not lose sight of one fact: In the foreseeable future, sufficient numbers of trained professionals will not be available to care for the Nation's mental health needs, including the control of alcoholism. We must train sufficient para-professional personnel to augment professional manpower. Recognition of the value of volunteer and indigenous groups is growing; no better example exists than Alcoholics Anonymous. Fortunately, the therapeutic disciplines and Alcoholics Anonymous have met, heard, and learned from each other.

Most therapists agree that recovered alcoholic persons can be of great value as counselors, but that professional guidance is essential. The risk of having alcoholic individuals (or, for that matter, any person suffering an intrapsychic illness) treated by inadequately trained personnel is that the latter may, often unconsciously, develop strong feelings that can be destructive to the patient to continuously challenge his therapeutic helper, plus his tendency to relapse, can be a severe test for anyone. These acts on the part of the patient may provoke destructive hostility, or defensive permissiveness to cover the hostility,

on the part of counselors improperly prepared to recognize and handle these feelings. And permissiveness can be just as destructive as hostility since it does not permit the therapist to set realistic and firm limits on the patient.

Group therapy has a wide acceptance in alcoholism treatment programs. This type of treatment is attractive for today's developing community alcoholism programs because it is usually less expensive than individual therapy. But group therapy should be attractive for today's developing community alcoholism programs because it is usually less expensive than individual therapy. But group therapy should be attractive not because it costs less but because it can prove effective in treating alcoholism. It cuts across three systems—intrapsychic, interpersonal, and the social small group—permitting the alcoholic patient to see himself more honestly, to view his relationship to other important figures more clearly, and to feel he is an integral part of a social system.

This type of therapy ranges from groups with intensive psychoanalytic orientation where unconscious motivations (even utilizing dream analyses of both patients and therapists) are probed . . . to community groups where problems of group living are paramount and the group itself has the function of effecting significant changes in the lifestyles of its members.

A form of group therapy now increasingly used with alcoholic patients is one involving a confrontation process. At some level of understanding, the alcoholic person himself is quite aware that he is destroying his life's potential. Alcohol, however, has become such a vital self-treatment he dares not admit the harm inflicted on himself by use of alcohol. He tries to kid others so that they will reflect back to him his own hope that drinking is not really such a serious problem. This denial of his drinking problem is so obvious it may simply look like a lie to an observer.

Continued next month

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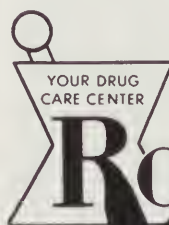
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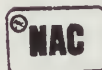
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APRIL 25, 26, 27, 1973
BALTIMORE CIVIC CENTER

APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Art and Hobby Exhibit
Medical and Chirurgical Faculty
1211 Cathedral St, Baltimore, Md 21201

1. Title of exhibit:
2. Amount of space required—depth, width, and height
3. Electrical or other requirements:
4. Name of exhibitor:
Please print
5. Address of exhibitor:
6. Telephone number of exhibitor:

An Art and Hobby Exhibit will be held during the 175th Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to THE BALTIMORE CIVIC CENTER, Baltimore, between 9:00 AM and 4:00 PM on Tuesday, April 24. They must be removed on Friday, April 27 between 2:00 and 5:00 PM. The Faculty cannot carry insurance on exhibits, but utmost care will be taken of them. There will be a watchman on duty when the meeting is not in session. Exhibitors' personal policies will probably cover the exhibit. All entries should be submitted as early as possible.

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by John Sargeant,
Executive Director

The Executive Committee at its first meeting of 1973, on January 11, took the following actions:

1. Declined to publish in the *Maryland State Medical Journal* information regarding patients who a) have filed malpractice actions against physicians, b) filed complaints against physicians which are found to be unjustified, and c) are chronic "deadbeats." This was done on advice of legal counsel because of the possibility of accusation being leveled against the Faculty charging intimidation of patients who seek needed medical services.
2. Authorized payment of certain sums involved in the legal defense of a member for a suit going back several years.
3. Named two physicians as cochairmen of an Ad Hoc Committee on AMA Membership:

J Emmett Queen MD, Baltimore
Carolyn H S Pincock MD, Silver Spring

4. Heard that the Comprehensive Health Planning Agency had only received a report on a Plan for Ambulatory Care Facilities and referred it to the Health Services and Facilities Committee for study and appropriate follow-up; that a proposal for a Comprehensive Health Plan had been received by the Agency, and that it will use this as a basis to develop the various phases of a more comprehensive health plan for personal health care services for the State.

In the first instance, the agency advised that acceptance of this report did not imply endorsement of it; in the second instance, the agency advised that input from consumers and providers would take place at the local level, or the "b" agencies.

The Executive Committee agreed to acknowledge receipt of these communications and continue to monitor activities in this regard.

5. Established a policy in connection with issuance of MD license plates, which will take place in 1975, as follows:
 - a) Restrict issuance of plates to two sets per physician
 - b) Charge an administrative fee of \$10 per set of plates

Physicians would determine if they wish to apply for such plates, use of which is optional with the physician.

6. Agreed to recommend the following to the Governor for appointment to Occupational Disease Board:

J Howard Franz MD, Baltimore
John M Dennis MD, Baltimore
Russell H Morgan MD, Baltimore

7. Agreed to cosponsor the TAP Institute (Trustees, Administrators, and Physicians) scheduled for Washingtonian Motel, Gaithersburg, Md, May 4-6, 1973. The institute would involve education regarding JCAH regulations, etc.
8. Agreed to a recommendation of the Faculty Subcommittee on Human Ecology that the following three names be submitted to the Secretary of Health and Mental Hygiene for possible appointment to the Air Quality Control Advisory Council:

Walter E Dandy MD, Baltimore
Jack C Childers MD, Baltimore
Robert L Cavanaugh MD, Baltimore

9. Authorized publication of the Faculty's document, A Survey of Professional Liability Incidence in Maryland, June 1971, as part of the Secretary of HEW's Commission on Medical Malpractice Report, provided appropriate credit is given.
10. Declined to hear a case on appeal from a local Peer Review Committee decision until such time as the remedies provided in Faculty Bylaws have been exhausted, but did agree to discuss the appeals mechanism with the attorney for the physician if he so desired.
11. Agreed to investigate the use of the term "doctor" by medical students when seeing hospitalized patients; also agreed to investigate the practice of having such students' written orders in hospital charts carried out before approval by a Resident or Physician.
12. Approved the 1973 budget for recommendation to the Council.

The Council met on Thursday, Jan 18, 1973 and took the following actions:

1. Agreed to recommend Emeritus Membership to the House of Delegates for certain physicians, on request of the component societies involved.
2. Agreed to waive 1972 dues for a physician on account of illness, at the request of the component society involved.
3. Approved recommendations of the Executive Committee nominating certain physicians to Maryland Blue Shield for consideration in its election process. Copies of this list are available to members on request.
4. Authorized the Committee on Emergency Medical Services to 1) consider a proposed plan for statewide emergency care and make recommendations to the Council in this regard, and 2) seek an audience with the Governor to discuss such a proposed statewide emergency medical care system and its implementation.
5. Deferred action on an addition to the Nurse Protocol dealing with the expansion of conditions under which services of Nurse-Midwives can be utilized, with the request that this be reconsidered at the next Council session.
6. Adopted the 1973 budget for operation of the Faculty. Copies are available to members on request.
7. Heard that a grant of \$3,000 has been made by the Regional Medical Program to the Faculty library for installation of a MEDLINE terminal. This will enable the library to communicate over telephone lines with the National Library of Medicine to query bibliographic references and obtain them within minutes through a printout at the Faculty's terminal. The library was urged to publicize existence of this new service for members and others.
8. Determined Faculty policy with respect to certain legislation introduced in the General Assembly at Annapolis.
9. Heard objections from representatives of the Montgomery and Prince George's County Foundations with respect to adoption of the Bylaws of the Maryland Foundation for Health Care. House of Delegates policy requires adoption of such bylaws and any amendments thereto, by either the Council or House.
10. Heard a progress report from the Chairman of the Board of the Maryland Foundation for Health Care, and accepted it with an expression of thanks for its timeliness and clarity.
11. Approved the Bylaws of the Maryland Foundation for Health Care as submitted by the Foundation.
12. Recommended that every effort be made by the Foundation to integrate and coordinate the changes recommended by the Prince George's and Montgomery County Foundations into the Foundation Bylaws.
13. Expressed itself as being opposed to granting of Active membership to Interns and Residents unless full active dues are paid for such privilege.



PAUL F GUERIN MD
Chairman
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Doctor-Patient Relationship: New Books

A few years ago, Michael Balint MD wrote that a satisfactory relationship between the invalid and his doctor is the first of all remedies. A look in the library's card catalog under the heading PHYSICIAN - PATIENT RELATIONS shows that this topic has been a prime concern among medical writers of all ages. The effectiveness of establishing a good rapport with the patient, and the usefulness of an accurate medical history are discussed in medical classics from the time of Hippocrates. During the last year, the library acquired five recent books on this topic.

"The ability to establish a satisfactory physician-patient relationship rests on the use of communication skills in the medical interview." So writes Robert E Froelich MD and F Marian Bishop in the introduction to *Medical Interviewing; a programmed manual* (2d ed, St Louis, C V Mosby Co, 1972, \$5). This manual, for the student beginning in clinical medicine, and for the practicing physician seeking to improve his interviewing skills, demonstrates alternative ways of responding to a patient, and aims at helping the student or physician to develop a feeling for the appropriate lead. The authors' method requires the reader to respond to questions or simulated situations, and then to compare their responses with those of the authors.

Iver F Small's *Introduction to the Clinical History* (2d ed, Flushing, NY, Medical Examination Publishing Co, 1971, \$3) is an outline guide to the medical history, intended primarily for the medical student, but also for the practicing physician desiring to improve his personal competence in interview techniques, medical history taking, and doctor-patient relationships.

Clinicians should find a useful tool in Dr Louis R M Del Guercio's *Multilingual Manual for Medical History Taking* (Boston, Little, Brown

& Co, 1972, \$6). This manual was designed for use by doctors in questioning and examining non-English-speaking patients. The book has six sections: French, Spanish, German, Italian, Polish, and Russian. Each section consists of 100 questions which represent a composite of various standard medical history forms from several eastern medical centers. The questions are worded so that they can receive a yes-or-no answer by the patient. Each question in the foreign language is followed by a phonetic transliteration. Each of the foreign words is reduced to syllables which, if pronounced exactly as in English, reproduce the sounds of the foreign language. In clinical tests, this simple phonetic system was found to work well enough for most patients to understand.

Reading between the lines: doctor-patient communication (New York, International Universities Press, 1972, \$7.50), by Lucille Hollander Blum, is a study of the psychological factors in the physician-patient relationship. In the introduction, Dr Blum states that the interpersonal relation between patient and physician is the keystone of medical practice. This book aims at an orientation on the part of the physician which will encourage insight into the full implications of the patient's verbal and nonverbal communications. Such an orientation will facilitate the physician's perception of the patient as a "total being." Effective treatment implies response on the part of the physician, not only to the patient's complaint or disorder, but to the "whole person."

Pedro Lain Estrado's *Doctor and Patient* (New York, McGraw-Hill, 1969, \$4.95) studies the physician-patient relationship from a historical point of view. Lack of human contact due to technical developments in diagnosis and treatment, socialized, "mass-production" medical care,

and other factors introduce a degree of conflict into the normal relationship between the patient and doctor. Dr Lain Estrado's book examines the physician-patient relationship historically and systematically. He shows what this relationship was like in the past, what it is now, and what he thinks it ought to be. The informative background, delightful illustrations (many in color) of artifacts illustrating the history of the physician-patient relationship, and easy reading style make this book one that would go well in any physician's personal library.

JOSEPH E JENSEN
Assistant Librarian

Calendar of Meetings

March 15—Baltimore Hospital Librarians Assoc, Union Memorial Hospital, Nursing School Library. Hostess: Mrs Elizabeth Streett, Librarian. Subject: Volunteer assistance in the professional library.

NEW ACCESSIONS — BOOKS (Arranged by Subjects)

REFERENCE WORKS

- Ref. **Medical aid encyclopedia for the home.** Nashville, T Nelson, 1972.
WB 120
.M4
Ref. **Research centers directory.** Detroit, Gale Research Co, 1960.
Q 180
.U5
.R4

CARDIOVASCULAR SYSTEM

- WG Ellison, Robert C
140 **Vectorcardiography in congenital heart disease.**
.E4 Philadelphia, Saunders, 1972.

DEFICIENCY DISEASES

- WD Manocha, Sohan L
105 **Malnutrition and retarded human development.**
.M2 Springfield Ill, Thomas, 1972.

GYNECOLOGY

- WP Workshop on Estrogen Target Tissues and Neoplasia, Buffalo, 1970
870
.W9 **Estrogen target tissues and neoplasia.** Chicago, Univ of Chicago Press, 1972.

IMMUNOLOGY

- QW **Basic immunogenetics.** New York, Oxford Univ Press, 1972.
541
.B3

INFECTIOUS DISEASES

- ZWC Goode, Stephen H
140 **Venereal disease bibliography, 1966-1970.** Troy NY, Whitston Pub Co, 1972.
.G7

LIBRARIES

- Z Middleton, Bernard C
271 **The restoration of leather bindings.** Chicago, American Library Association, 1972.
.M5
Z Weisman, Herman M
1001 **Information systems, services, and centers.** New York, Becker & Hayes, 1972.
.W4

MEDICINE

- WB Austin, Mary
369 **Acupuncture therapy.** New York, ASI Publishers, 1972.
.A9

MUSCULOSKELETAL SYSTEM

- WE Zachar, Jozef
500 **Electrogenesis and contractility in skeletal muscle cells.** Baltimore, University Park Press, 1971.
.Z1

NERVOUS SYSTEM

- WL Gastaut, Henri
385 **Epileptic seizures.** Springfield Ill, Thomas, 1972.
.G2
WL Nebylitsyn, Vladimir D
102 **Fundamental properties of the human nervous system.** New York, Plenum Press, 1972.
.N3

OBSTETRICS

- ZWQ Floyd, Mary K
225 **Abortion bibliography for 1970.** Troy NY, Whitston Pub Co, 1972.
.F5

OPHTHALMOLOGY

- WW Contact Lens Seminar, 5th, Ohio State University, 1970
355
.C7 **Symposium on the flexible lens.** Saint Louis, Mosby, 1972.
WW International Symposium on the Lacrimal System, 1st, Mexico (City), 1970
208
.I6 **The lacrimal system.** Saint Louis, Mosby, 1971.

PATHOLOGY

- QY White, Wilma L
26.5 **Practical automation for the clinical laboratory.**
.W5 2d ed. Saint Louis, Mosby, 1972.

PEDIATRICS

- WS Nadas, Alexander S
290 **Pediatric cardiology.** 3d ed. Philadelphia, Saunders, 1972.
.N1

PHARMACOLOGY

- ZQV Campbell, Irene R
292 **Biological aspects of lead.** US Govt Print Off, Washington, 1972.
.C3

PSYCHIATRY

- BF Jung, Carl G
1031 **Four archetypes.** London, Routledge and K Paul, 1972.
.J9
WM Lowenfels, Albert B
274 **The alcoholic patient in surgery.** Baltimore, Williams & Wilkins, 1971.
.L9
WM Zinberg, Norman E
270 **Drugs and the public.** New York, Simon & Schuster, 1972.
.Z7

PUBLIC HEALTH

- WA McCormac, Billy M
754 **Introduction to the scientific study of atmospheric pollution.** Dordrecht, Reidel, 1971.
.M1

HISTORY OF MEDICINE

- History
WZ Ackerknecht, Erwin H
70 **Medicine at the Paris hospital, 1794-1848.** Baltimore, Johns Hopkins Press, 1967.
.GF7
.A2
- History
WZ Blunt, Wilfrid
100 **The compleat naturalist.** New York, Viking Press, 1971.
.C5
- History
HB Boner, Harold A
871 **Hungry generations.** New York, Russell & Russell, 1971, c1955.
.B7
- History
WZ Fishbein, Morris
345 **Medical writing.** 4th ed. Springfield Ill, Thomas, 1972.
.F5
- History
M Franklin, Benjamin
Some account of the Pennsylvania Hospital. Baltimore, Johns Hopkins Press, 1954.
- History
WZ Frothingham, Richard
100 **Life and times of Joseph Warren.** New York, Da Capo Press, 1971.
.W2
.F7
- History
QH Gasking, Elizabeth B
471 **Investigations into generation, 1651-1828.** Baltimore, Johns Hopkins Press, 1967.
.G3
- History
WZ Grant, Madeleine P
100 **Alice Hamilton.** London, New York, Abelard-Schuman, 1967.
.H2
- History
QH Haldane and modern biology. Baltimore, Johns Hopkins Press, 1968.
431
.H2
- History
WZ Marshall, Helen E
100 **Mary Adelaide Nutting.** Baltimore, Johns Hopkins Press, 1972.
.N8
- History
WM Psychosomatic classics. New York, Karger, 1972.
90
.P8
- History
WZ Rothstein, William G
70 **American physicians in the nineteenth century: from sects to science.** Baltimore, Johns Hopkins Press, 1972.
.AA1
.R8
- History
WL Stevens, Leonard A
11 **Explorers of the brain.** New York, Knopf, 1971.
.S8
- History
WB Stevens, Rosemary
50 **American medicine and the public interest.** New Haven, Yale Univ Press, 1971.
.AA1
.S8

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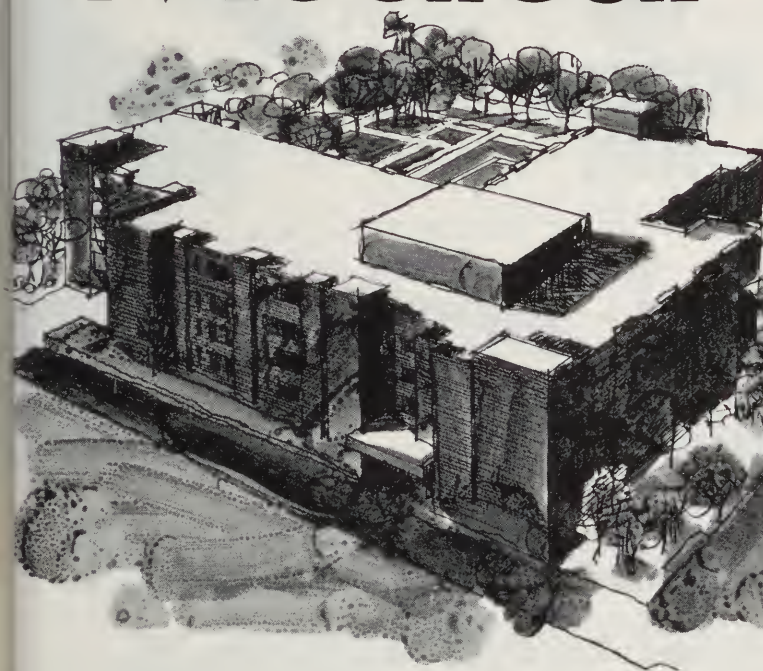


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Baltimore City Medical Society

Drug Use and Abuse

DONALD M PACHUTA MD
Editor

Introduction to a New Feature — Drug Use and Abuse

DONALD M PACHUTA MD
DAVID A BLAKE PhD

Dr Pachuta is Assistant Professor of Medicine, University of Maryland School of Medicine; and Chairman, Committee on Drugs, Baltimore City Medical Society.

Dr Blake is Associate Professor and Chairman, Department of Pharmacology and Toxicology, University of Maryland School of Pharmacy.

There is growing recognition that traditional sources of information on drugs such as textbooks, journal articles, detail men, the PDR, and postgraduate courses, have not adequately met the needs of the practicing physician today. Reasons for the existence of this problem include lack of clinically relevant published material; fragmentation of the science of pharmacology; drug use outside the medical sphere, with too narrow a focus, and too much nonscientific information being disseminated about this problem; biased advertisements, publicity, and opinion; and the gap between rational pharmacology and empirical therapeutics.

In an attempt to conform to the usual requirement for scientific publication (eg, complete references for all statements and a thorough review of the literature), much of what is now available is too lengthy and too specialized to be generally useful. Moreover, the usual editorial review process often delays examination of urgently needed information beyond the period of optimal utility. These problems have contributed to the unfortunate situation that exists today with regard to the physician and his utilizable drug knowledge; ie, a lack of confidence in prescribing, improper prescribing, lack of identification of the problems of drug abuse and addiction, and uncertainty about what to do once these problems have been appreciated.

While much of the recent emphasis on drugs

has been directed toward abuse and addiction, it is undesirable to focus on this area without consideration of the legitimate medical uses of the drugs involved. Furthermore, much of the drug information available to physicians and the public is scientifically inaccurate, prejudiced, emotion-laden, and moralizing. This has led to mass confusion, wasting of valuable funds, and many failures in current efforts to solve drug-related problems.

A recent example of this comes from the National Coordinating Council on Drug Education (The National Education Association issued a similar but independent report) who recently evaluated 220 films on drugs.¹ They rated 8% unacceptable, 31% totally unacceptable, 53% restricted to use only with careful guidance, and only 16% "scientifically and conceptually acceptable." According to a statement by the president of the Council, who decried the multi-million dollar "drug education hustle," the majority of the films are "so inaccurate, so unscientific, so psychologically unsound that they are doing more harm than good." The Council further noted that all seven films directed at blacks were totally unacceptable and the information in them "stereotyped and misleading and the values conveyed biased and racist."

Purpose and Scope

To help remedy this situation, this column will appear as a regular feature in the *Journal*. It will attempt to provide current, useful, and practical information to the practicing physician from the four major areas involved in drug use and abuse (All too often one of these receives emphasis at the expense of the others):

- 1) The *DRUG* itself.
- 2) The *PERSONALITY* of the user.
- 3) The social *SETTING* in which a drug is used or abused.

- 4) The role of the *PHYSICIAN* in the first three.

In addition, the column will provide a forum for the presentation of both sides of controversial issues.

To accomplish these tasks, material will be drawn from the entire spectrum of medical and social sciences, with some emphasis on local problems. Attempts will be made to gather information from all possible sources including those who use and abuse drugs, since the effects of drugs may be quite different when taken outside the medical sphere, and most of the literature concentrates on medical effects only.

Criticism and comment are welcome as well as suggestions for topics that the reader thinks would be helpful.

Role of the Baltimore City Medical Society in Drug Use and Abuse in Maryland

DONALD M PACHUTA MD

The Committee on Drugs of the Baltimore City Medical Society first met on Feb 23, 1972 and decided to dedicate its efforts toward education. It was thought that this area was the major failure in present drug-abuse programs, funding, and goals. Vast amounts of confusion, and erroneous, nonscientific information, even among physicians, have resulted in a great deal of harm. We planned to disseminate only objective, scientific information. We felt an urgency to distinguish user from abuser from addict as well as to separate drugs and drug categories rather than grouping everything together as "drug abuse." The latter is a practice all too common with media, law enforcement agencies, the public, and even many physicians. The failure to make all of these distinctions has often led to disastrous consequences.

To accomplish our educational or re-educational goals, we stated the following objectives:

- 1) The creation of a Drug Information Newsletter (and possibly a regular column in the *Maryland State Medical Journal* for the dissemination to physicians, professionals, schools, hospitals, and the general public of information about current drug-related problems.

- 2) To study the problems of the legal sources of amphetamines and barbiturates. We believe that far too many of these are manufactured than could even be prescribed by physicians and

Future Plans

Articles now in the planning stages include concepts about the nature of drug abuse; drug abuse as self-destructive behavior; diagnosis and evaluation of nonmedical drug use; emergency and nonemergency treatment of drug-related problems; discussions of new problems with phencyclidine, methaqualone, amphetamines, barbiturates, and others; controversies about methadone, marijuana and others; hallucinogenic drugs; the Maryland Anonymous Drug Testing Program; physician prescribing habits; and the role of the physician in all the problems of drug use and abuse.

References

1. National Coordinating Council on Drug Education, Press Release, Dec 12, 1972.

that many of these drugs end up on the street and clearly *not* by physicians' prescriptions. It may be that if physicians (as did Med-Chi on amphetamines) took a strong stand against prescribing certain commonly used barbiturates, that their manufacture might drastically diminish or cease altogether. We propose to do a mail survey of all physicians and pharmacies in Baltimore by anonymous questionnaire to gather data on this problem.

- 3) To sponsor and run a voluntary, noncredit evening drug education course at the University of Maryland Baltimore Campus for anyone who wants to attend from any of the medical, dental, nursing, or social work schools in town. If interest is large enough and we have enough appropriate people on the Committee, we could sponsor several such courses at different locations.

- 4) To attempt to evaluate current programs in drug education in the City as well as professional schools.

- 5) To investigate the type of care given to drug users in emergency rooms and to provide information useful in the care of such persons. Also to study, particularly, the referral of such patients after their immediate medical problems are over. It is our opinion that this area is one of our greatest failures, ie, with few exceptions, there is nowhere to send such people for information or counseling they *will* trust.

6) To investigate the possibility of liaison with emergency rooms and the general public so that anyone can obtain information on request, either for treatment purposes, or education.

7) To attempt to reach the many thousands of young people who consider or use drugs but are not addicts and have no related medical problems by a media campaign that may include:

- a) Public service radio or television shows or even "spot" commercial type messages
- b) Newspaper publicity
- c) Liaison with schools and the Board of Education
- d) Providing speakers to various groups requesting them

8) To attempt to educate physicians and the adult public at large with scientific, objective information rather than biased, emotional moralizing.

Since its inception, the Committee has established liaison with many agencies and groups in the field of drug abuse. We have disseminated drug information in the Society's Newsletter. The Committee sponsored a scientific program for the Society attended by over 100 physicians.

All received copies of the Med-Chi booklet on Drug Abuse Diagnosis and Emergency Treatment, as well as the Drug Abuse Administration referral book. We have recruited a large number of people from all disciplines to serve on the Committee.

A number of subcommittees are investigating the controversies surrounding methadone, legalization of marijuana, and restriction of methaqualone.

Also, we have sent letters to the heads of all departments, emergency rooms, and hospitals serving Baltimore offering them an educational program. We would like to sponsor such programs in every hospital. The Committee now has its own Speakers' Bureau that provides speakers on request. We have already participated in a number of postgraduate courses and hospital programs. An eight-hour postgraduate course for credit is now being planned for the late spring. This will be given in the Medical and Chirurgical Faculty Building and offered to all physicians and allied professionals in the State.

Ultimately, we hope to be a major source of accurate, scientific, nonbiased consultation and education for the entire state of Maryland.

Recent Activities of the Medical and Chirurgical Faculty in the Control of Drug Abuse

JOSEPH I BERMAN MD MPH

Chief

Department of Community Medicine
Sinai Hospital of Baltimore

A recent article in this *Journal* by Dr Louis Kolodner reviewed the recent activities of the Medical and Chirurgical Faculty in the area of drug abuse control and education.¹ The article is of major importance because it describes how physicians have, through a state medical society, played a major role in the complex task of controlling licit, as well as illicit drug use.

The early activities of the Faculty in the area of drug abuse, beginning in 1967, revolved around the then controversial use of methadone for treatment of hard-core opiate addicts. The Mediation Committee of the Faculty established a permanent Subcommittee on Narcotic Prescribing Practices of Physicians in early 1969 (since renamed Subcommittee on Medical Treatment and Drug Programs), in order to assist physicians

who were becoming increasingly involved in the prescribing of methadone to the large number of addicts in the Baltimore area. The monitoring of the practices of physicians who demonstrated difficulties in the distribution of methadone was an early and major contribution of the subcommittee and set the stage for future activities in the control over distribution of other drugs, most particularly the amphetamines and a variety of the sedative-hypnotics.

As control of methadone maintenance programs has increased on the Federal level, and with a variety of restrictions being placed upon private physicians dispensing it from their offices, the subcommittee has spent less and less time with physicians having problems with methadone distribution and an increasing amount of time with other physicians who have gotten into difficulties through the distribution of the amphetamines and sedative-hypnotics.

The subcommittee now meets regularly each month to deal with reports received from several

sources concerning the prescribing habits of physicians. A close relationship has developed with the Division of Drug Control of the Department of Health and Mental Hygiene. Investigations by this division which appear to indicate that a private physician may be improperly prescribing controlled drug substances are sent to the subcommittee for review. Some complaints are received by other physicians, as well as an occasional written complaint sent in by the general public. The reports are carefully scrutinized by the members of the subcommittee and the physician named in the report is asked to appear at a meeting to discuss the alleged problems.

As already noted, while early in the subcommittee's history physicians called before it were usually involved in the prescribing of methadone, the emphasis has shifted considerably recently to problems involving amphetamines and sedative-hypnotics. Some physicians have demonstrated a surprising lack of understanding of the effects of their prescribing on the community and the jeopardy in which they place themselves by prescribing these drugs indiscriminately. Other physicians have demonstrated a lack of knowledge concerning the real efficacy of the drugs that they are prescribing.

The subcommittee, which represents a broad base of knowledge about both drug abuse and the problems of practice, has for the most part been successful in demonstrating to physicians who appear before it the nature and scope of their prescribing problems. Occasionally, the alleged changes are found to be unjustified. The subcommittee itself has no punitive powers, but on occasion has recommended the practice of certain physicians be investigated by appropriate Faculty committees.

In the 1972 session of the State legislature, House Bill 80 required that the State Department of Health and Mental Hygiene, in cooperation with the Medical and Chirurgical Faculty of Maryland, set up regulations for the prescribing of methadone, amphetamines, and methamphetamines. The subcommittee undertook the task of formulating these guidelines, forwarded to the Department of Health and Mental Hygiene in late summer 1972 for action.

This subcommittee is a reflection of the medical faculty's concern for the public welfare and is a mechanism for insuring that physicians themselves do not contribute to the drug problem in the State of Maryland.

References

1. Kolodner I.J: History and current account of Med-Chi role in drug abuse in Baltimore and in Maryland. Md State Med J 21:57-62, April 1972.



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Definitive Therapy in Cardiopulmonary Resuscitation

DONALD H DEMBO MD
Head, Division of Cardiology
Maryland General Hospital
Assistant Professor
University of Maryland School of Medicine

No other aspect of cardiopulmonary resuscitation is as controversial as drug therapy. Little data are available, but considerable clinical evidence has accumulated indicating the value of drug therapy as an adjunct in resuscitation and postresuscitation care. It is recognized that certain drugs remain controversial while others are currently and generally accepted.

Current, Generally Accepted Therapy

Therapy for Acidosis

Metabolic acidosis rapidly ensues in cardiac arrest. In the presence of acidosis, the myocardium responds poorly to endogenous and exogenous catecholamines. The early and continued administration of sodium bicarbonate can restore a normal pH rendering the myocardium responsive to circulating and administered catecholamines.

Five hundred cubic centimetres of a 5% sodium bicarbonate solution (297.5 mEq) can be administered per hour or prefilled syringes containing 50 cc of a 7.5% solution (44.6 mEq) are available for administration at ten-minute intervals. Where available, arterial blood gas analysis is recommended for determination of blood pH and base deficit as guidelines in the maintenance of an approximately normal pH. Metabolic alkalosis from excessive therapy should be avoided.

Epinephrine

Experimentally, epinephrine can be shown to produce ventricular fibrillation in the laboratory animal. Restoration of electrical activity in instances of asystole and the augmentation of defibrillation in ventricular fibrillation following

the administration of epinephrine are now well documented. Epinephrine has been shown to increase myocardial contractility, to elevate perfusion pressure, to lower defibrillation threshold, and, in some instances, restore myocardial contractility in instances of electromechanical dissociation.

The standard adult dose is 0.5 cc of 1:1000 solution, usually diluted to 10 cc and administered intravenously during each five minutes of resuscitation effort. Intracardiac administration may be required where an intravenous route has not been established.

Calcium Chloride (Calcium gluconate)

Calcium increases myocardial contractility, prolongs systole, and enhances ventricular excitability. Sinus impulse formation can be suppressed and sudden death following intravenous calcium has been described, particularly in fully digitalized patients. Calcium appears to be particularly useful, however, in profound cardiovascular collapse (electro-mechanical dissociation) and has also been effective in restoring an electrical rhythm in instances of asystole.

The usual dose of 5 cc of a 10% solution of calcium chloride or 10 cc of calcium gluconate can be injected at intervals of 10 minutes. It is possible, but not proven that repeated large doses of calcium may significantly elevate calcium blood levels with deleterious effect. Calcium must not be administered *together* with sodium bicarbonate since a precipitate of calcium carbonate may ensue.

Atropine Sulfate

Atropine reduces vagal tone, enhances A-V conduction and accelerates cardiac rate in sinus bradycardia. It is most useful in preventing arrest in profound sinus bradycardia secondary to myocardial infarction. By accelerating the heart rate, cardiac output may be improved and ventricular fibrillation may be less likely secondary

to ectopic electrical activity. The usual adult dose is 0.5 mg to 1.0 mg given intravenously.

Lidocaine

Lidocaine raises fibrillation threshold and exerts its antiarrhythmic effect by increasing the electrical stimulation threshold of the ventricle during diastole. In usual therapeutic doses, there is no change in myocardial contractility, systemic arterial pressure, or absolute refractory period. It is particularly effective in depressing myocardial irritability where successful myocardial defibrillation repeatedly reverts to ventricular fibrillation. Lidocaine is of no value in asystole or profound cardiovascular collapse. Lidocaine is particularly effective in the control of multifocal premature ventricular beats and episodes of ventricular tachycardia. The usual dose of 50 to 100 mg intravenously can be followed by continuous intravenous infusion (500 mg in 500 cc of dextrose and water) at a rate of up to 3 mg per minute.

Alternate Drugs

Vasoactive Drugs

(Levarterinol, Metaraminol, Isoproterenol)

The use of potent peripheral vasoconstrictors, has been challenged because of the reduction of cerebral, cardiac and renal blood flow. Isoproterenol in association with volume replacement has been thought to be more effective in maintaining perfusion of vital organs. The choice of vasoconstrictor or peripheral vasodilator and positive inotropic agent remains controversial in cardiac arrest and the immediate postresuscitation period. The ideal drug for the support of blood pressure is not available in the clinical armamentarium.

Corticosteroids

Often, massive doses of steroids have been utilized in the treatment of hemorrhagic and endotoxin shock. Their use during cardiac arrest and for shock of cardiogenic origin has not been proven. Empirically, large doses of dexamethasone have been useful for the prevention or attenuation of cerebral edema sometimes following successful resuscitation. Doses of 4-8 mg at six-hour intervals have been recommended.

Potent Diuretics (Furosemide and ethacrynic acid)

The use of potent diuretic agents to sustain renal blood flow in the postresuscitation period and to decrease cerebral edema has been widely advocated. The specific value of this measure has not been established with certainty. Doses of up to 100 to 200 mg have been utilized successfully in producing diuresis.

Mannitol

The use of an intravenous osmotic diuretic is helpful in reducing elevated cerebrospinal fluid

pressure and cerebral edema. Such agents are contraindicated in the presence of renal impairment and test dosing is required. 1.5 to 2 gms/kg of body weight is given in 30 to 60 minutes with 50 to 200 gm within a 24-hour period. Titration with mannitol to promote a continuous urine output has been advocated.

Propranolol

The use of beta adrenergic blocking agents may appear unphysiologic, but the antiarrhythmic properties have proven useful in instances of repetitive ventricular tachycardia or ventricular fibrillation where maintenance with lidocaine cannot be achieved. Propranolol can be administered intravenously in a dose of 3 mg.

There is little evidence that other drugs are of significant value in the acute arrest situation. Certainly underlying disease for which specific therapy is available should be corrected (ie, congestive heart failure utilizing digitalis).

Electrical and Mechanical Therapy

Intubation with the early administration of high concentrations of oxygen continues to be of major importance in reducing hypoxia. There is no evidence that lung damage occurs with high concentrations of oxygen used for periods of less than 24 hours. Ventricular premature beats secondary to hypoxia are easily demonstrated in the laboratory animal.

Electrical Countershock

It should be recognized that different defibrillation units are inconsistent as to the energy to which capacitors are charged and the defibrillator shock delivered. In ventricular fibrillation, it has been customary to deliver a maximal shock (200 or more often 400 watts seconds). The optimal delivered shock has not been established. Broad clinical experience has demonstrated that the blind delivery of a defibrillating countershock where the electrical mechanism is unknown can and should be accomplished. In coronary care units where a defibrillator is immediately available, the prompt delivery of electrical countershock with the onset of ventricular fibrillation is indicated. Failure to restore a functional rhythm is an indication for emergency measures and definitive therapy in cardiopulmonary resuscitation.

It remains apparent that successful resuscitation is directly related to the rapidity with which a functional spontaneous rhythm can be restored. It is becoming increasingly apparent that stabilization and resuscitation at the scene of an arrest is more likely to result in survival. Even the most skillfully continued emergency measures during transportation sharply reduce the likelihood of victim survival.

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Mar	29-31	National Conf on Urologic Cancer , Shoreham Hotel, Washington. No regis fee. Sponsor: Amer Cancer Society. Contact: Sidney L Arje MD, Natl Conf on Urologic Cancer, c/o ACS, 219 E 42nd St, New York NY 10017.
Mar	29-31	Johns Hopkins Med Institutions , Baltimore. 1st anl symposium, Recent Advances in Diagnostic Radiology & Nuclear Medicine, Turner Auditorium. 18 hrs cr. \$175 gen fee, \$75 residents' fee. Contact: Dr Frederick P Stitik, Dept of Radiology, Johns Hopkins Hosp, Baltimore Md 21205.
Apr	5	Management of Diabetes Mellitus & Complications , Turner Auditorium, Johns Hopkins. Sponsors: Johns Hopkins Univ Sch of Med & Maryland Diabetes Assoc. Contact: D H Lockwood MD, Maryland Diabetes Assoc, 407 Reisterstown Rd, Baltimore Md 21208.
Apr	25-27	Med-Chi 175th Anl Mtg , Civic Center, Baltimore.
Apr	26-28	4th Natl Congress on Med Ethics , Washington Hilton Hotel. Sponsor: AMA. Contact: Judicial Council, AMA, 535 N Dearborn St, Chicago Ill 60610.
May	4-6	Penna Society of Anesthesiologists , anl mtg, Hotel Hershey, Hershey Pa. Contact ASA, 515 Busse Highway, Park Ridge Ill 60068.
May	9-11	Clinical Aspects of Hypertension , Jefferson Med Col, Philadelphia. Contact: ACCP, 112 E Chestnut St, Chicago Ill 60611.
May	16-18	Clinical Auscultation of the Heart , Georgetown Univ, Washington DC. Contact: ACP, 4200 Pine St, Philadelphia Pa 19104.
May	16-18	Rheumatic Disease—Clinical & Immunological Aspects , Univ of Texas Southwestern Med Sch, Dallas.

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Mar	26-30	Cardiology 1973 , Topics of Current Interest. Mt Sinai Sch of Med, New York City, Americana Hotel.
Apr	4-6	Recent Advances in Diagnosis & Mgt of Pulmonary Disease , Va Mason Med Cen, Seattle.
Apr	24-27	Pulmonary Disease , Univ of Pa Sch of Med, Philadelphia.
Apr	25-27	Hepatobiliary Disease in Clinical Practice , Hilton Hotel, San Francisco. Sponsors: Presbyterian Hosp of Pacific Med Cen & Dept of Gastroenterology, Univ of Calif, San Francisco.
Apr	25-27	Advances in Diagnosis & Mgt of Infectious Disease , Univ of Wisconsin, Madison.
May	21-25	Internal Medicine: Current Concepts of Clinical Problems , Univ of Cincinnati Med Cen, Cincinnati.
May	21-25	International Medicine: Current Concepts of Clinical Problems , Univ of Cincinnati Med Cen, Cincinnati.

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| Apr | 2-6 | Clinical Anesthesiology for the General Practitioner , Oklahoma City. |
| Apr | 13-15 | 10th Anl Spring Scientific Mtg, Va Society of Anesthesiologists , Richmond. |
| Apr | 23-25 | 23rd Anl Postgrad Symposium on Anesthesiology , Univ of Kansas Med Cen, Kansas City. |
| Apr | 27 | Muscle Relaxants & Ventilation , Ohio State Univ, Columbus. |
| Apr | 28-29 | Obstetrics Anesthesia , Univ of Tennessee Col of Med, Memphis. |
| Apr | 28-29 | ASA Regional Refresher Crs , Grove Park Inn, Asheville NC. |
| May | 4-10 | Biennial Western Conf on Anesthesiology , Dunes Hotel, Las Vegas. |
| May | 14-18 | Review of Basic Med Sciences Related to Study & Practice of Anesthesiology , Univ of Tennessee Col of Med, Memphis. |
| May | 24-26 | 7th Anl Symposium on Critical Care Med , Pittsburgh. |

MISCELLANEOUS MEETINGS

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| Mar | 26-31 | Selected Topics in Genitourinary Roentgenology , Playboy Plaza Hotel, Miami Beach. Contact: Manuel Viamonte MD, Det of Radiology, Univ of Miami Sch of Med, Box 875, Biscayne Annex, Miami Fla 33152. |
| Mar | 29-30 | 26th Natl Conf on Rural Health , Statler-Hilton Hotel, Dallas. Contact: Dept of Rural Health, Div of Med Practice, 535 N Dearborn St, Chicago III 60610. |
| Apr | 1-4 | 1st Anl Spring Mtg, American Col of Surgeons , Americana & Hilton Hotels, New York City. 8 postgrad crs. Contact: ACS, 55 E Erie St, Chicago III 60611. |
| Apr | 4-6 | Critical Care Program for Nurses & Physicians . Nashville. Sponsors: Amer Col of Chest Physicians & Vanderbilt Univ Sch of Med. Contact: ACCP, 112 E Chestnut St, Chicago III 60610. |
| Apr | 9-12 | Amer Academy of Pediatrics , anl spring session, Sheraton-Boston Hotel, Boston. Contact: ACP, 1801 Hinman Ave, Evanston III 60204. |
| Apr | 16-19 | 1973 Amer Industrial Hlth Conf , Denver Hilton Hotel, Denver. Sponsors: Ind Med Assoc & Amer Assoc of Ind Nurses. Contact: American Industrial Health Conference, 150 N Wacker Dr, Chicago III 60606. |
| Apr | 13-14 | 7th Natl Congress on Socioeconomics of Health Care , Marriott Motor Hotel, Chicago. Sponsor: AMA Council on Med Sv. Contact: AMA, Div of Med Practice, 535 N Dearborn St, Chicago III 60610. |
| May | 2-5 | Understanding Pulmonary Disease , Univ of Toronto. Contact: ACCP, 112 E Chestnut St, Chicago III 60611. |
| May | 4-5 | British Columbia Oto-Ophthalmological Society , anl conf, Hotel Vancouver, Vancouver BC. Contact: D A Gillanders MD, 165 E 15th St, North Vancouver BC. |

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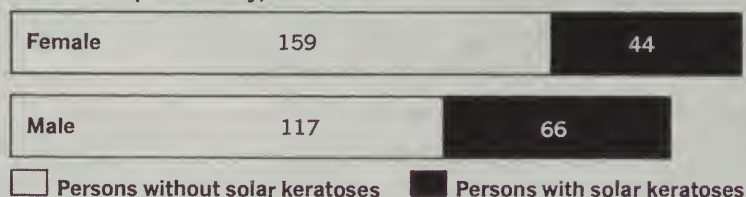
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"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

**Are there significant
differences in bioavailability
and clinical predictability
among drug products?**

Opinion

Results of a questionnaire to
7,000 physicians:

44.6%

**Agree there is a significant
difference**

24.9%

Believe there is no difference

30.5%

Had no opinion

Are there significant differences in bioavailability and clinical predictability among drug products?

Teacher of Medicine

Alfred Gilman, Ph.D.
Wm. S. Lasdon
Professor & Chairman
Department of
Pharmacology
Albert Einstein
College of Medicine of
Yeshiva University



I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equiva-

lency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

Clinical Predictability More Important Than Price

Although the question of price has been greatly exaggerated, it is true that patients can on occasion save money on generic drugs. But you are not going to dare attempt to save money if it jeopardizes the patient's health. Let's return to the example that has become very prominent in recent years, that of the cardiac glycosides. They are probably the most toxic drugs we use with respect to the small difference between a maximally effective dose and a toxic dose. When you are dealing with drugs of this type, the first concern must be clinical predictability. At the risk of variations in bioavailability, it would be sheer folly to try to save the patient what might amount to maybe \$10 or \$20 a year. The physician cannot manage his patient unless he is sure that the drug he is prescribing has the same positive effect each time the prescription is renewed. This is especially significant when the patient takes the product, not for months, but for the rest of his life.

Maker of Medicine

C. J. Cavallito, Ph.D.
Executive Vice President
Ayerst Laboratories



minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequiva-

lent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalence have appreciably improved.

Product Selection Based on Patient Response
Improved specifications and standards can better assure the equivalence of *drug substances*. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the *drug product*, not the *drug substance*, that the physician, pharmacist, nurse and patient-customer utilize. How can these indi-

viduals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Although equivalence of different preparations of a *drug substance* may be defined by certain physical, chemical or biological characteristics, identity is not always assured even though these characteristics may be described in compendia such as the USP, NF or defined by other specific source standards. Moreover, even with equivalent drug substances, similar pharmaceutical *products* can be produced by different manufacturers such that these products are biologically or therapeutically inequivalent.

A Growing Awareness of Potential for Nonequivalence

As experience increases with drug substances derived from different sources and under different conditions, it should be possible to establish specifications in sufficient detail to minimize the potential for their nonequivalence. However, there is general agreement that product therapeutic equivalence would still not be assured even if one could

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.



The Pharmaceutical Manufacturers Association
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MINOCIN® made the difference in just eight days.*

Clinical Data:

Patient: 47-year-old male.

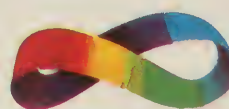
Diagnosis: Severe pyoderma, left hand.

Culture: *Staphylococcus aureus*, coagulase positive and sensitive to MINOCIN.

Temperature: 102° F

Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat*, 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.

Concomitant therapy: None.†



Semisynthetic

MINOCIN®
MINOCYCLINE HCl

Capsules, 100 mg: 2 *stat*, 1 q 12 h.

Indications: For the treatment of susceptible infections; e.g., *E. coli*, *D. pneumoniae*. For full list of approved indications consult labeling.

Contraindications: Hypersensitivity to any tetracycline.

Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has also been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug.

Pregnancy: In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. **Newborns, infants and children:** All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease

in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

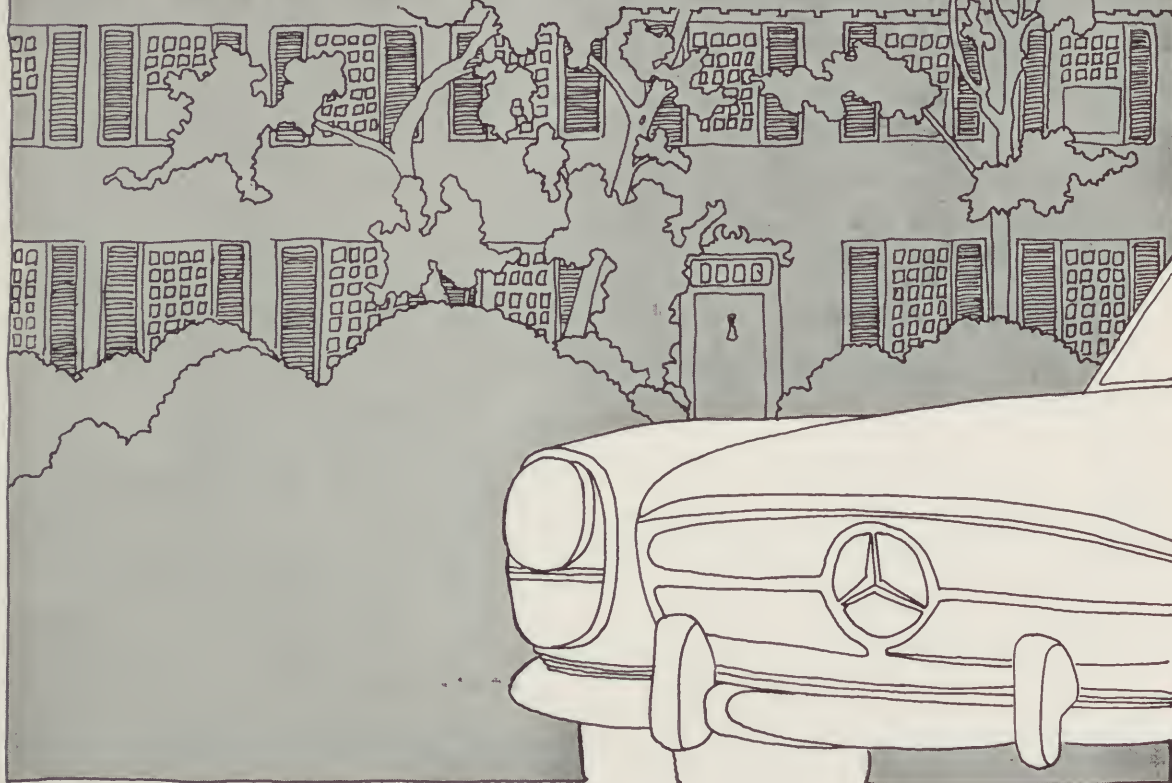
Adverse Reaction: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. **Skin:** maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). **Renal toxicity:** rise in BUN, dose-related (see "Warnings"). **Hypersensitivity reactions:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. **Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. **CNS:** (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

*Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.
†Case Report, Clinical Investigation Department, Lederle Laboratories.



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Effect on mental acuity: Usually minimal on proper maintenance dosage.

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**5-mg, 10-mg, 25-mg capsules
up to 100 mg daily in
severe anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debili-

tated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the

elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



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Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

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Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane (flurazepam HCl) at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

Sleep with consistency— no waning of therapeutic effectiveness

Over multiple nights of therapy, no waning of drug effectiveness was noted. There was consequently no need to increase dosage during the study periods. It stands to reason that the fewer repeat or incremental doses needed to sustain sleep, the lower the total cost of the sleep medication. Consistent effectiveness is the measure of Dalmane (flurazepam HCl) economy.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, nonbarbiturate agent proved effective and relatively safe for relief of insomnia.

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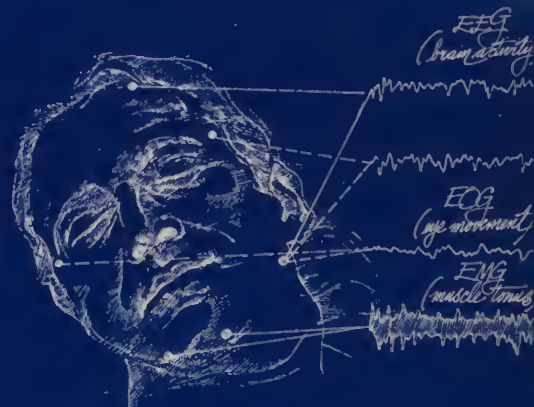
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One 30-mg capsule *h.s.*—usual adult dosage.
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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or

recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years

of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effect. Employ usual precautions in patients who are severely depressed, or with



ent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech,

confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients.

Elderly or debilitated patients: 15 mg initially until response is determined.

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your medical faculty at work

by John Sargeant,
Executive Director

The Executive Committee met on Thursday, Feb 15, 1973 and took the following actions:

1. Accepted a report from the Peer Review Committee which found no evidence requiring action by it. This report dealt with payments to relatives as well as those disabled by Black Lung Disease, such money coming from the Social Security Trust Fund. It had been alleged that physicians were interpreting such medical criteria too broadly in making awards; but it was learned that the US Congress established by statute the criteria used.
2. Made recommendations to the Department of Motor Vehicles for the appointment of the following to the Medical Advisory Board:

Talmadge C Reeves MD, Salisbury, Psychiatrist

C Rodney Layton MD, Centerville, Family Practice

3. Adopted the following policy in connection with selection of speakers for various dedicated fund lectures:

That the Program and Arrangements Committee (and other committees of the Faculty, if appropriate) consult with the individuals responsible for formation of the Dedicated Fund (such as descendants or relatives) whenever feasible, in making selection of speakers whose honorarium and expenses are to be paid from such funds.

It is to be recognized that this may not be possible in many instances, in which case the above policy need not be implemented.

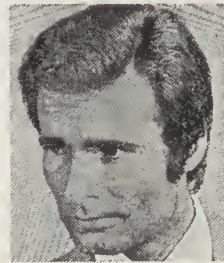
4. Agreed to look into the question of Medicaid fees for the following:
 - a) Anesthesia services provided in the Salisbury area
 - b) Obstetrical services provided in the Salisbury area
 - c) Kidney dialysis fees recently established by the Department of Health and Mental Hygiene
5. Agreed to oppose legislation being sought by the Health Services Cost Review Commission that would bring within its purview:

"Hospital-based physicians irrespective of the Institutions' and Physicians' billing methods"
6. Approved granting scholarship funds to the son of a deceased physician under certain conditions and circumstances.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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MRS ROBERT A REITER
Editor

woman's auxiliary

HEALTH MANPOWER COMMITTEE

The Health Careers Committee of the medical auxiliary received a new name this year—Health Manpower Committee. The change in name was a result of the added concern this year with health manpower distribution as well as with recruitment and training. This committee of the Auxiliary has always been active both on a state level and through the 12 county auxiliaries in encouraging young people to pursue a health career. This is done largely through auxiliary scholarships, health fairs, and health career clubs in the high schools (formerly Future Nurses Clubs).

As state chairman of Health Manpower, it is my job to disseminate information and suggestions I receive from the national auxiliary to county Health Manpower chairmen so they can plan a project to meet a need in their community. There are 250 allied health occupations available today. We try, through our medical auxiliary, to help many people and the medical profession by stimulating interest in these careers. Auxiliaries do this by working with school guidance counselors, helping to organize health career clubs in the high schools, planning hospital tours and health fairs, and working with other groups.

A health manpower workshop was held at Med-Chi in October at which county chairmen could obtain information to use and distribute within their communities, and could also discuss ideas for projects that could meet a need in their local area. Our auxiliary purchased two books from the AMA for each county: 1) the 1972 *Allied Medical Education Directory* which contains a state-by-state listing of schools and hospitals offering allied medical education programs and 2) *Financial Information National Directory*, a resource of financial aid for health career students which includes 1,000 sources of funds for health-career training listed by state and occupation. Auxiliaries were urged to order more copies for distribution to guidance counselors, schools, libraries, etc in their area. Many chair-

men made this one of their projects for the year, and they found counselors and students anxious for the information they were able to provide.

Other health manpower chairmen have been visiting schools to offer auxiliary help with health career clubs and to talk to students interested in learning more about health careers. They have shown films and slides, arranged speakers, and taken students on tours of local hospitals. The national auxiliary makes available package programs on many subjects, such as health manpower, drug abuse, alcohol, and sex education. These package programs contain ideas and material on how to set up a program, how to attract the proper audience, and how to present the subject to best advantage. At least two auxiliaries have used the health manpower program.

Our state auxiliary has been working closely with the State Health Careers Club, an organization of high school health career clubs from throughout the state. We help the students arrange state meetings, plan programs for them with health professionals, and arrange "go-see" trips to hospitals. We have visited Maryland General Hospital in Baltimore and Washington County Hospital and Western Maryland State Hospital in Hagerstown. We also assist them in publishing their newsletter, *The Candlelight Express*, several times a year. At the annual meeting of the medical auxiliary in April we will present a \$300 scholarship to a member of this club, and will then attend the club's annual convention in Cumberland on May 5.

This has given an idea, I hope, of what is being done by the Health Manpower committee of the medical auxiliary. I believe it illustrates that one of our most valuable contributions as wives of physicians can be to serve as a source of information and a link between the health professionals and the community.

MRS EDMUND V NIKLEWSKI
Health Manpower Chairman

Doctors in the News

Recent promotions at the University of Maryland School of Medicine, as announced by Dean John H Moxley III, include:

C Alek Alexander MD to associate professor in preventive medicine.

George Entwisle MD, who has been a professor of preventive medicine at the school since 1958, has also been named associate professor of medicine.

Appointed clinical associate professors were **Ronald N Kornblum MD**, pathology, and **Richard Warbasse MD**, preventive medicine.

MDs appointed as assistant professor include:

Guislaine Godenne, psychiatry; **Ronald Goldman**, medicine; **Charles Earl Hill**, family practice; **Perry Hookman**, medicine; **Mary Lou McIlhenny**, medicine; **Stanley Miniken**, surgery; and **Mariano Veigo**, child psychiatry.

Also, **Aristides Alevizatos**, medicine; **Albert M Antlitz**, medicine; **Gary A Fleming**, pediatrics; **Ellen G McDaniel**, psychiatry; **Chris Papadopoulos**, medicine; **Mario L Penafiel**, anesthesiology; and **William Rever Jr**, surgery.

Pinar Ozand MD was promoted to professor of pediatric research.

●
George O Eaton MD has resigned as Medical Director of Baltimore's Children's Hospital after 17 years' service. Dr Eaton will remain active on the staff of the hospital and as a trustee.

His replacement is **Edmond J McDonnell MD**, formerly Assistant Medical Director.

●
George H Yeager MD retired in February as director

of the University of Maryland Hospital after a 44-year career at the School of Medicine.

Readers of this Journal will recall that Dr Yeager served as Editor from its founding in 1952 until 1966.

He has seen the progression of the hospital not only from an administrator's view, but through the eyes of a physician as well. He was professor of clinical surgery before taking on the directorship in 1965. During his term as director, he established a reputation for his attention to the details which make a hospital run effectively.

His biggest accomplishment has been improvement of the physical facilities of the hospital, Dr Yeager feels. When he came to University, department heads were working under undesirable conditions, he says, and there were no amenities for private patients. Especially with the opening of the north hospital wing, he says University can now provide satisfactory facilities for all types of patients.

Dr Yeager has also seen the development of intensive care units. At the beginning of his career, acutely ill patients were scattered throughout the hospital. Now this system has given way to centralized intensive care units in which each patient can be assured that he is within immediate reach of highly skilled practitioners and the most advanced technical equipment.

With his retirement, Dr Yeager will continue his international traveling, beginning with several months on a consulting job in Bogota, Columbia. After that, his plans are not firm.

Until a successor is chosen,



Dr Yeager

the hospital will be administered jointly by Dr John H Moxley, dean of the medical school, and Jack Robinette, administrator of the hospital.

"George Yeager has devoted his entire professional life to University Hospital," said Dr Moxley. "He accomplished many things before taking on the directorship of the hospital, when it was at a low point," he said, "including founding the surgical research lab and the surgical vascular clinic."

Dr Moxley added that Dr Yeager has developed the hospital into a thriving institution, maintaining the respect of his staff in the process. "He is one of the most respected men in the country in the field of surgery, as well as among hospital administrators," said Dr Moxley.

●
Due to pressure of his private practice, **Samuel P Scalia MD** has resigned as director of the TB and VD Control programs of the Baltimore County Department of Health. After 16 years' service with the County, he will not sever his affiliation completely but will be available as a consultant.



Dr Besson

Edwin H T Besson MD, Catonsville, has assumed the presidency of the medical staff at Baltimore's St Agnes Hospital. He also becomes chairman of the executive committee.

He received his MD from the University of Maryland School of Medicine. In addition to his pediatric practice, Dr Besson serves as an instructor in pediatrics at his alma mater. He has also served as chairman of the Department of Pediatrics at St Agnes.

Other officers of the medical staff for 1973 are **David B McIntyre MD**, immediate past-president; **Ralph Updike MD**, President-elect; and **Elie K Fraiji MD**, Secretary-Treasurer.

Maxwell N Weisman MD, Director, Division of Alcoholism Control, Maryland Department of Health and Mental Hygiene, has been named to serve as a consultant to the Pan American Health Organization which is developing programs related to alcohol and drug abuse in Latin American countries.

Dr Weisman, who had been Professor of Biology at the University of Puerto Rico prior to his studying medicine at the University of Amsterdam in the Netherlands, was invited to serve with the Pan American regional office of the World Health Organization because of his experience in the fields of alcoholism and drug abuse and because of his command of the Spanish language.

At the annual meeting of the Maryland General Hospital Medical Staff, three new officers were appointed for the year 1973. Those elected (all MDs) were **Edwin H Stewart Jr**, President of the Staff, **Neil A Robinson**, Secretary, and **John W Barnaby**, Treasurer.

The selection of Chiefs of Departments was also announced by Dr Norman Tarr, Medical Director of MGH.

The surgical staff re-elected these MDs: **Ross Z Pierpont**, Chief of Surgery; **James R Karns**, Chief of the Department of Medicine; **D McClellan Dixon**, Chief of Obstetrics; and **Theodore Kardash**, Chief of Gynecology.

Newly elected Chiefs of Departments include **Albert Steiner MD**, succeeding **Jerome Snyder MD** as Chief of the Otolaryngology Service, and **Alfred A Filar Jr MD**, taking over from **Henry B Wilson MD**, as Chief of Ophthalmology. Both Dr Steiner and Dr Filar were elected to three-year terms of office.

Other recent additions to the MGH medical staff are **Drs Dole Baker** and **James J Carey**. Dr Baker was selected a Director of Education for the Otolaryngology service.

The Department of Medicine announced the appointment of **James J Carey MD** as an Associate in the Nephrology Division.

Eight Maryland doctors have been certified as Diplomates of the American Board of Anesthesiology:

John L Atlee, Bethesda
Denis E Bowyer, Wheaton
Chang Nam Cho, Baltimore
Leovina D Duran, Silver Spring
Don F Lysons, Rockville
Novarro C Stafford, Silver Spring
Wayne K Thorpe, Bethesda
Kou-Chen Yu, Bethesda

The ASA also advises that **Harmon Carl Landesman MD**, Baltimore, has been certified as a Fellow of the American Board of Anesthesiology.

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Infant mortality in the United States fell from a rate of 47 per 1,000 live births in 1940 to 18.6 in 1972, the lowest rate ever, according to the National Center for Health Statistics.

The directors of Taylor Manor Hospital, Ellicott City, have appointed **Frank J Ayd Jr MD** as Director of Professional Education and Research.

Dr Ayd's appointment is part of a continuing series of planned expansions of the facilities and services of Taylor Manor Hospital for its patients and for the community, according to the news release.

He is actively engaged in the practice of psychiatry, in clinical research, and in writing and lecturing.

Among the many awards he has received is the 1970 Taylor Manor Hospital Psychiatric Award "in recognition of his contributions to biological psychiatry and as a tribute to the genius of scientists dedicated to easing emotional and psychiatric suffering and to restoring mental health."



GIFTED—Charles N Davidson MD, right, is shown receiving a gift of golf clubs at a testimonial dinner given in his honor on Saturday, Jan 20, 1973 at the Maryland Golf and Country Club, Bel Air. Over 100 physicians and wives, together with close relatives and friends, joined in the tribute honoring Dr Davidson for his many kindnesses and interest shown over the years. The event was arranged by J Howard Franz MD, who kept it completely secret from the guest of honor until part way through the evening. The presentation was made by John S Green III MD, left, as Dr Davidson's daughter, Mrs William S Neal, witnessed the proceedings.

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CHURCH HOME AND HOSPITAL

Church Home and Hospital was chartered in 1855 and opened its doors three years later. It is a private, nonprofit, 325-bed community facility located in Baltimore's inner city, two blocks from the Johns Hopkins Hospital with which it has some teaching affiliation.

Church Home provides both acute general health services and a retirement home for aged women.

Although Episcopal in origin, its services and administration are nonsectarian in nature.

Foreign Medical Graduates in Baltimore Hospitals

A recent report of the Policy and Planning Committee of the Baltimore City Medical Society on foreign medical graduates in Baltimore area hospitals may be of general interest to *Journal* readers.

The report listed 20 Baltimore area hospitals as having 1519 physicians on house staffs. Of these physicians, 711 (46.9%) were FMGs, 808 (53.1%) were USGs. Of the 711 FMGs, hospitals identified national origin of 693 (97%).

FMG distribution in Baltimore hospitals follows no pattern and varies from 0% to 100% with 68 national origins being reported.

Only 11% of FMGs in Baltimore hospitals come from Europe, the land area most studied in all US schools.

An additional 17.3% of FMGs come from Central and South America, which are

Church Home maintains a nationally accredited School of Nursing (founded in 1894) as well as a medical education program for the training of interns and residents.

The Hospital, with approximately 1,156 employees and 300 Medical Staff members, continued its "Tradition of Concern" in fiscal year 1971-72 serving a total of 9,770 inpatients and 40,080 Emergency Room and Clinic patients.

T G Whedbee Jr is Director of the Hospital.

studied only casually and only in relation to European or US conquests and imports.

The largest number of FMGs (483 or 69.7%), nearly three quarters of the total, come from nations still generally poorly studied in depth by high schools or colleges. These are the nations of Asia, Africa, Pacific Islands, and the Near/Middle East.

Problems arise in these relationships and include those which are personal, interpersonal, social, and professional.

The Baltimore City Medical Society desires to improve the care given by FMGs to hospitalized patients, to make more pleasant the professional education of these physicians, and to be of help to FMGs and to their wives who have newly arrived in the Baltimore area.

To these ends, the Society participated in a meeting held

in July 1972 by the Baltimore Area Council for International Visitors to orient FMGs to the educational and recreational opportunities available to them. The Auxiliary of the BCMS also has special programs for the wives of these physicians.

A concentrated program in the business aspects of medical practice is also offered to newly licensed physicians bi-annually.

Other questions raised in 1971 concerning FMGs will be discussed by the Policy and Planning Committee of the Baltimore City Medical Society from time to time.

Sight Savers

The University of Maryland School of Medicine has received an annual grant of \$5,000 in unrestricted funds from Research to Prevent Blindness Inc to speed studies of blinding diseases at the department of ophthalmology. The RPB grant, renewable each year, is specifically designed to promote development of new techniques and advanced concepts in the saving of sight. Over the past four years, RPB has awarded \$20,000 in similar grants to the medical school.

Dr R D Richards, head of ophthalmology at the medical school, pointed out that the "no-strings" award differs from most grants in that it gives freedom to carry out important research activities for which other funds are not available. "This is the kind of money we need to launch pioneering studies and to grasp research opportunities as they occur," he said. "The return on such an investment is enormous."

Doctors take note...

MARYLAND AREA

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|-----|-------|--|
| May | 4-5 | 4th Anl Sports Med Symposium , Gorman Auditorium, Georgetown Univ Sch of Med, Washington. Sponsor: Georgetown Univ Sch of Med. Contact: Dr P M Palumbo Jr, 8027 Leesburg Pike, McLean Va 22101, phone 893-3232. |
| May | 4-6 | Penna Society of Anesthesiologists , anl mtg, Hotel Hershey, Hershey Pa. Contact ASA, 515 Busse Highway, Park Ridge Ill 60068. |
| May | 9-11 | Clinical Aspects of Hypertension , Jefferson Med Col, Philadelphia, Contact: ACCP, 112 E Chestnut St, Chicago Ill 60611. |
| May | 16-18 | Clinical Auscultation of the Heart , Georgetown Univ, Washington DC. Contact: ACP, 4200 Pine St, Philadelphia Pa 19104. |

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- | | | |
|------------|---------|--|
| May | 21-25 | Internal Medicine: Current Concepts of Clinical Problems , Univ of Cincinnati Med Cen, Cincinnati. |
| May | 21-25 | International Medicine: Current Concepts of Clinical Problems , Univ of Cincinnati Med Cen, Cincinnati. |
| May
Jun | 29
1 | Recent Advances in Endocrinology & Clinical Applications , Royal Victoria Hosp, Montreal. |
| Jun | 4-8 | Hematology , Univ of Washington Sch of Med, Seattle. |
| Jun | 11-15 | Oncology & Chemotherapy , Univ of Southern Calif, Los Angeles. |
| Jun | 18-22 | Clinical Aspects of Blood Transfusion , Michigan State Univ, East Lansing. |
| Jun | 25-29 | Advances in Internal Medicine: 1973 Perspectives , Univ of Alberta & Univ of Calgary, Banff, Can. |

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

(For info on these mtgs, contact ASA, 515 Busse Highway, Park Ridge Ill 60068.)

- | | | |
|-----|-------|--|
| May | 4-10 | Biennial Western Conf on Anesthesiology , Dunes Hotel, Las Vegas. |
| May | 14-18 | Review of Basic Med Sciences Related to Study & Practice of Anesthesiology , Univ of Tennessee Col of Med, Memphis. |
| May | 24-26 | 7th Anl Symposium on Critical Care Med , Pittsburgh. |
| Jun | 11-15 | Symposium: Basic Sciences Related to Anesthesiology , Montefiore Hosp & Med Cen, Bronx NY. |

MISCELLANEOUS MEETINGS

- | | | |
|------------|---------|--|
| Apr | 22-28 | Oxygen Transport to Tissue , international symposium, Charleston SC. Sponsors: Med Univ of South Carolina & Clemson Univ. Contact: C B Gudaitis, PR Director, Med Univ of South Carolina, 80 Barre St, Charleston SC 29401. |
| Apr | 29-30 | AMA Congress on Environmental Health , Ambassador West Hotel, Chicago. Contact: Dr A J Finkel, Dept of Environmental Hlth, AMA, 535 N Dearborn St, Chicago Ill 60610. |
| Apr
May | 29
4 | Amer Col of Ob&Gyn , Philadelphia. Tuition-free seminar in family planning. Sponsors: ACOG & Temple Univ. Contact: Dr Howard Osofsky, Temple Univ, 3400 N Broad St, Philadelphia Pa 19104, phone 215-221-4110. |
| May | 2-5 | Understanding Pulmonary Disease , Univ of Toronto. Contact: ACCP, 112 E Chestnut St, Chicago Ill 60611. |

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|-----|-------|--|
| May | 4-5 | British Columbia Oto-Ophthalmological Society , anl conf, Hotel Vancouver, Vancouver BC. Contact: D A Gillanders MD, 165 E 15th St, North Vancouver BC. |
| May | 9-12 | 17th Anl Postgrad Crs on Fractures & Other Trauma , Sheraton-Chicago Hotel, Chicago. Sponsor: Chicago Committee on Trauma of the ACS. Contact: Amer Col of Surgeons, 55 E Erie St, Chicago Ill 60611. |
| May | 12-15 | Medical Society of NJ , 207th anl mtg, Haddon Hall, Atlantic City. No out-of-state regis fee. Contact: Med Society of NJ, PO Box 904, Trenton NJ 08605. |
| May | 16-18 | Rheumatic Disease—Clinical & Immunological Aspects , Univ of Texas Southwestern Med Sch, Dallas. |
| May | 18-19 | Amer Assoc Med Clinics , Northeast regional mtg, Gov Morris Inn, Morristown NJ. Sponsor: Summit NJ Med Group. Contact: Amer Assoc of Med Clinics, PO Box 949, Alexandria Va 22313. |
| May | 21-24 | Amer Col of Ob&Gyn , 21st anl clin mtg, Bal Harbour Fla. Contact: ACOG, 1 E Wacker Dr, Chicago Ill 60601. |
| May | 29-31 | Master Interpretation of Clinical Electrophysiology , postgrad seminar, Contemporary Hotel, Disney World, Lake Buena Vista Fla. Sponsors: Univ of Miami Sch of Med & Council on Clinical Cardiology of Amer Heart Assoc. Contact: Dr Sidney Blumenthal, Assoc Dean, Univ of Miami, Miami Fla 33152. |
| Jun | 14 | Amer Electroencephalographic Society , 8th anl crs on Clinical Electroencephalography, Statler-Hilton Hotel, Boston. Contact: Dr D W Klass, EEG Crs Dir, Mayo Clinic, 200 First St SW, Rochester Minn 55901. Their 27th anl mtg will follow Jun 14-15. |
| Jun | 22-23 | Emergency Dept Legal Institute , O'Hare Regency House, Chicago. Sponsor: ACEP & Hlth Law Cen of Aspen Systems. Contact: R T Johnson, ACEP, 241 E Saginaw St, East Lansing Mich 48823. |
| Jun | 23-24 | AMA Anl Mtg , New York. Contact AMA, 535 N Dearbon St, Chicago Ill 60610. |

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MEET YOUR NEW COUNCIL MEMBERS

The series on new 1972-1973 Council members concludes this month with the profile on Charles H Ligon MD, Sandy Spring, Md. Dr Ligon assumes the office of Councilor for the South Central District at the conclusion of the 1973 Annual Meeting.

A native of upper Montgomery County, Dr Ligon received his BS from Haverford College in 1938 and his MD from Johns Hopkins in 1942.

He was with the US Public Health Service in 1946-1947. Since completing service with the US Coast Guard in 1947, he has been in private practice as a general practitioner and surgeon, except for time out in 1955 and 1956 to serve with the US Navy. He has offices in the Sandy Spring Medical Center.

Before becoming 1961 President of the Montgomery County Medical Society, he served two years as Vice President and three years as Secretary-Treasurer. He has also served continuously since 1958 as either Delegate or Alternate to the Faculty House of Delegates.

He is on the active staff of the Montgomery General Hos-

pital in Olney where he was Chief of Staff from 1963 to 1966.

He had previously served as Secretary-Treasurer and Vice Chairman. Prior to this he served as a member of the Board of Directors.

In addition to AMA and Med-Chi memberships, he also holds membership in the American Academy of General Practice.

Other medical-related memberships include the Medical Advisory Board to the Montgomery County Council, Montgomery County Welfare Board, and Metropolitan (Washington) Area Medical Council.

He is also a member of the Johns Hopkins Medical and Surgical Society.

In the business and civic area, he serves as a trustee of the Friends House Nursing Home in Sandy Spring, was a trustee of the Sandy Spring Friends School from 1961 to 1971, and is a director of the Sandy Spring National Bank.

Dr Ligon is married and has two sons; one is a senior in the University of Maryland Veterinary School; the other practices law in Rockville,



Dr Ligon

Md. His daughter is a junior at Prescott College in Arizona.

His wife, Roberta, is active in the United States Pony Clubs.

Dr Ligon spends his spare time working on antique cars.

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Booklets Available

The AMA has compiled a summary of pertinent changes in Medicare, Medicaid and Maternal and Child Health laws resulting from enactment of the 1972 Social Security Amendments. Many are of significant interest to physicians. Write Legislative Dept, AMA for a free copy.

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From the Subcommittee on Alcoholism of the
Medical and Chirurgical Faculty of the State
of Maryland

alcoholism section

TREATMENT OF ALCOHOLISM — PART II

Reprinted from "First Special Report to the US Congress on Alcohol and Health from the Secretary of Health Education and Welfare," December 1971, DHEW Publication (HSM) 72-9099.

The inability to face up to the reality, however, is largely an unconscious mechanism and needs to be attacked as the first order of therapeutic business. An individual psychotherapist may find his attempts to break through the patient's defenses deflected by the desperate alcoholic patient who reasons, "After all, what does he really know about it?" In the group setting, however, similarly afflicted people confront each other with the fact that each one is, indeed, in the same boat. How obvious the rationalizations of someone else seem! Confrontation with these transparencies by one's own peers seems less threatening and is easier to accept, especially when a patient can move back and forth between being the confronter and the confronted. The presence of the professional therapist prevents the session from deteriorating into scape-goating or ganging up on a patient who is not yet ready to "take on" the full implications of this type of therapy.

Sometimes role-playing or psychodrama facilitates group therapy. Let's just pretend, the therapist suggests, you are the rebellious son, the cast-out daughter, the long-suffering wife, the overprotective mother, the indifferent father. Roles are interchanged skillfully. This is make-believe and patients can "ham it up," playing the roles as they appear in their imaginations. They are assuming the parts of other people, and thus they do not bear the threat of self-revelation. But how real and revealing the stage action is to both the group-audience and the players! Poignant and change-effecting therapeutic sessions often involve a sudden coalescence of love and support by the group, sometimes following a tearful breakthrough of long-hidden

emotions revealed by an actor.

Varieties of sensitivity training and marathon techniques have also emerged in recent years to be incorporated in some therapy groups. These techniques increase the feeling, tone, and intimacy of groups of alcoholic patients. These modifications seem to fit in with theoretical assumptions about the group therapy process. The only reservations in applying these methods more often are adequate screening of patients who can benefit from these group therapy methods and the need for trained group leaders.

Sensitivity groups have the general purpose of exploring the here and now of how the members feel about each other. The members gain a learning experience by seeing how each comes across to others. This encourages the patients to drop their individual facades and to become more honest in their interpersonal relations, first within and then outside of the group.

As its title implies, the marathon group meets over a prolonged period, lasting perhaps 40 hours. A patient may be able to keep his mask intact over a short interval, but this becomes increasingly difficult to maintain as time lengthens. Pretenses tend to break down and real feelings come out.

Learning theory has been brought into the field of alcoholism treatment with the hypothesis that alcoholism is maintained because it is learned and reinforces as a behavior that engenders important rewards. In trying to account for the persistence of alcohol dependence or addictive drinking, it is always tempting to extrapolate

from common experience of alcohol-induced euphoria and to imagine that for the alcoholic person the immediate pleasure of drinking negates the prospect of its many aversive social and health consequences. The profound depression, dysphoria, and anxiety observed in the alcohol-dependent person during the course of chronic heavy alcohol ingestion challenges this type of simplistic explanation. Instead, some learning theorists hold that acceptance by the alcohol-dependent person of the consequences of his gross use of alcohol suggests that the pain he is seeking to assuage is extreme, and that it is this assuagement which constitutes the "immediate reward," thus overriding the foreseeable but delayed punitive consequences.

Treatment based on learning theory involves the use of positive or negative reinforcement techniques, or both kinds, as the behavioral therapist tries to help the patient alter his alcoholic behavior by retraining his form of learning response. Aversive therapy is a form of negative reinforcement; it consists of giving the patient a painful experience and associating it with the use of alcohol. If successful, any consideration of drinking thereafter reflexly evokes a mental association with the painful or aversive stimulus, and the idea of drinking is rejected.

Examples of aversive stimuli are painful electric shocks, drugs that produce violent vomiting, or a drug that paralyzes the musculature and produces a sense of suffocation. As is true of other aversive techniques, the enduring effectiveness of these negative reinforcement methods is unsure unless they are backed up with other forms of help. They are not popular with some professionals for fear they might be unknowingly used to vent unconscious hostile feelings toward alcoholic patients.

Modes of positive reinforcement based on learning theory, which would make not-drinking a more rewarding experience than drinking, could be expected to prove more effective in altering behavior. Specific techniques in applying this aim have only begun to be developed experimentally by behavior therapists, although in essence this aim underlies most psychotherapeutic programs as they try to develop increased self-esteem, group approval, and renewal of human contacts.

Conflicts that arise between behavioral therapists and other psychological schools are not over the question whether reward reinforces while punishment deters behavior. That is self-evident. The issue concerns what really constitutes reward and punishment. The psychoanalytic theorist would hold that for the obsessively

guilty, pain and punishment could be rewarding while success could be painful.

Much accommodation is being made today between learning and other motivational theories. The difference, as well as the growing accommodation between the schools of thought, may be illustrated by the following models: In an attempt to bring about certain responses, the behavioral therapist manipulates the stimuli to be fed into the "black box" (the brain with all its complexities and unknowns) and the responses that are emitted; the black box itself does not interest him. On the other hand, the concerns of the psychoanalytically oriented therapist and his patient are with the black box itself and with conflicts and motivations contained in it. This therapist avoids applying stimuli, and does not try to establish desirable responses; his quest is for insights, which he believes will allow the needed behavioral changes.

Other techniques that have been tried in the treatment of alcoholism include the use of hypnosis and LSD. Hypnosis can be used to explore feelings and memories that are not readily available to conscious experience but play an important role in precipitating drinking episodes. Posthypnotic suggestions can be given that make abstinence seem pleasurable and drinking painful. This use of hypnosis is an extension of the important impact a therapist can have upon his patient through suggestion and exhortation.

LSD has been utilized to evoke dramatically the patient's awareness of his buried emotions and his human qualities. While some controversy remains, LSD treatment does not appear to offer significant help to alcoholic patients, and surveys of hospital-based programs show that LSD, hypnosis, and aversive therapies are not widely used.

Psychoactive drugs have made a major impact on the treatment of important psychiatric disorders since the early 1950s. These drugs, along with changes in community attitudes about mental illness, have been significantly responsible for the steady decline in numbers of hospitalized psychiatric patients. Most impressive has been the impact of the phenothiazines, a group of major tranquilizers, on schizophrenia and, more recently, lithium salts in the treatment and prevention of manic-depressive psychosis. Less certain is the relative balance of good and harm from the use of the minor tranquilizers in softening the blows of everyday life that are experienced in an exaggerated way by neurotic patients.

Thus, enthusiasm over the antidepressant or mood-elevating drugs has diminished. Much

uncertainty exists about the use of chemical compounds to modify the anxiety and depression that reflect the intrapsychic stress experienced by alcoholic persons. The use of sedative and tranquilizing compounds may be essential in treating alcohol-withdrawal syndromes and to prevent delirium tremens; their long-term use, however, is fraught with a risk of addiction in the very individuals who are already prone to an addictive response. Therefore, most experienced physicians use such drugs judiciously, usually reserving them for crisis situations. Which drugs are best is controversial, and the placebo effects of drugs are sufficiently high to make it difficult to demonstrate a superiority for any one drug that can be repeated by many investigators and clinicians.

Since 1948, one drug—disulfiram (Antabuse)—has had a major impact on the treatment of alcoholism. It remains a favorite of many physicians though others seem reluctant to use it. Disulfiram is, in itself, a relatively inert compound. But it has the effect of interfering with the metabolism of alcohol after its first conversion to acetaldehyde in the liver, by blocking the further breakdown of the acetaldehyde. This results in an increased amount of acetaldehyde in the blood. Since acetaldehyde is very toxic, severe and even dangerous symptoms develop if alcohol is consumed when disulfiram is present in the body. Disulfiram is slowly removed from the body, and a patient has taken this medication must wait several days after discontinuing it before he can drink safely.

Physicians who prescribe this drug might demonstrate the danger of drinking to the patient by having him undergo a mild disulfiram-alcohol reaction under carefully controlled conditions, but usually a careful explanation is adequate.

The drug itself is not a sufficient therapeutic program. Combined with other psychological rehabilitative techniques, disulfiram can be a most useful tool, but it is not a panacea. In the motivated alcoholic patient, it can “buy time” for him when he has an impulse to drink. During that interval he has time to reconsider his best long-range interests.

Disulfiram is not a drug to be used without careful concern for the medical state of the patient. While it causes relatively few serious side effects in itself, a person in a weakened state might have an attack of acetaldehyde poisoning if he drank an alcoholic beverage while taking disulfiram. This could be dangerous for a person suffering from such conditions as arteriosclerotic heart disease, cirrhosis, severe kidney dis-

ease, diabetes mellitus, or any serious debilitating medical disorder. Careful medical examination and psychological considerations should precede the prescription of this compound.

The question of hospitalization for the alcoholic patient is usually generally agreed on when he is acutely intoxicated, or suffering from serious medical complications that would require hospital care even if he did not abuse alcohol or suffer from alcoholism. The reluctance of many general hospitals and physicians to accept this responsibility discriminates, in effect, against the indigent patient. The private patient who usually has a family doctor, can gain admission to a hospital—though his diagnosis may be masked by vague phrases such as gastrointestinal disorder or fever of undetermined origin. A psychiatric hospital may admit him as having an acute depressive reaction.

Sometimes, the indigent patient may be cared for in a detoxification center operated by city authorities, such as in St Louis or Washington, DC. A local city or county hospital may also have a detoxification center. Too often, however, the unofficial detoxification center is the city jail, where medical care for the person in an acute alcoholic episode is likely to be a matter of chance.

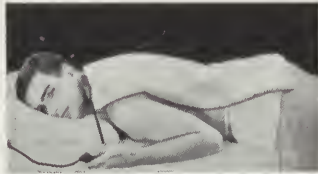
Whether or not detoxification is needed, hospitalization for rehabilitative and psychological care is not always available in State mental hospitals and private psychiatric hospitals. Most specialists agree that hospitalization is indicated if the patient needs detoxification, is suicidal, homicidal, or unable to terminate a drinking bout unless removed from the source of alcohol by temporary confinement. Not all professionals agree, however, that hospitalizing the alcoholic person for other reasons is indicated; they fear a regressive sheltering or institutionalizing effect of the hospital which may run counter to the need to learn to live in the normal community. Uncertainty also exists as to whether the alcoholic patient should be housed with other psychiatric patients or placed in a special hospital or special unit.

Hospitalization does have the major advantage of getting hold of the alcoholic person long enough to begin instituting various therapeutic techniques that can then be continued after discharge. For example, interpersonal and social small-group system intervention such as family therapy and Alcoholics Anonymous can be started during this time, and a foundation laid for necessary aftercare.

To be continued

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executive director's newsletter

April 1973

ANNUAL MEETING

Advance copies of the program for the 1973 Annual Meeting will be in the mail shortly to all members. An outstanding program has been developed by the Program and Arrangements Committee that should attract all those interested or involved in improving their knowledge.

With the requirement now in effect for 150 hours of Continuing Medical Education every three years, attendance should zoom to a new high. Programs qualify for credit towards American Academy of Family Physicians, AMA, and the Board of Medical Examiners requirements.

MEDLINE NOW INSTALLED

By May 1 our MEDLINE terminal, connected on-line with the National Library of Medicine in Bethesda, should be operational in our library. The entire medical community in the state will be eligible for this literature-searching service without charge. Instructions and request forms will be available from the library as soon as the service is implemented.

Medline will be in operation during the Annual Meeting in the Scientific Section of the exhibits. Members are urged to see how efficiently and effectively this service operates.

LEGISLATIVE ROUNDUP

Be on the alert for the last issue of The Assemblyman. This will be devoted to occurrences in the General Assembly during the recently completed legislative session.

Physicians and others should be aware of new legislation with which they may have to comply. Faculty publication listing all such rules and regulations is in the process of revision and will be available some time in July 1973.

NEW PUBLICATION

Plans are under way for issuance of a new publication devoted to activities of the Maryland Foundation for Health Care. To be published on a regular basis will

be a Newsletter keeping physicians and members of his staff up to date on Foundation projects and proposals.

ANNUAL
MEETING
RESOLUTIONS

A copy of the Reference Committee report to the House of Delegates for consideration Friday, April 27 is available to Faculty members. Component Societies and all members of the House of Delegates receive this routinely.

The report discusses and recommends action to the House of Delegates on the resolutions introduced.

TAP
INSTITUTE

A TAP Institute has been scheduled for May 4-6, 1973 at the Washingtonian Motel, Gaithersburg Md. Of interest to Trustees, Administrators, and Physicians, the program will explain and offer solutions to "current hospital management problems." Main emphasis will be on an internal quality assurance program that will, by conforming to JCAH standards, qualify the facility to become or remain accredited.


It is being cosponsored by the Faculty, Maryland Hospital Association and the JCAH. Further information can be obtained through the Faculty office.

AWARD
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Your Executive Director has been notified by the American Society of Association Executives that he has successfully completed a qualifying examination and can use the initials CAE (Certified Association Executive) following his name. In order to retain this classification a minimum number of hours of continuing education must be maintained during each three-year period.

This is the first time this award has been given. Only 75 Association Executives across the country were permitted to take the examination last December.

The award will take place formally during the ASAE meeting in New Orleans in August 1973.


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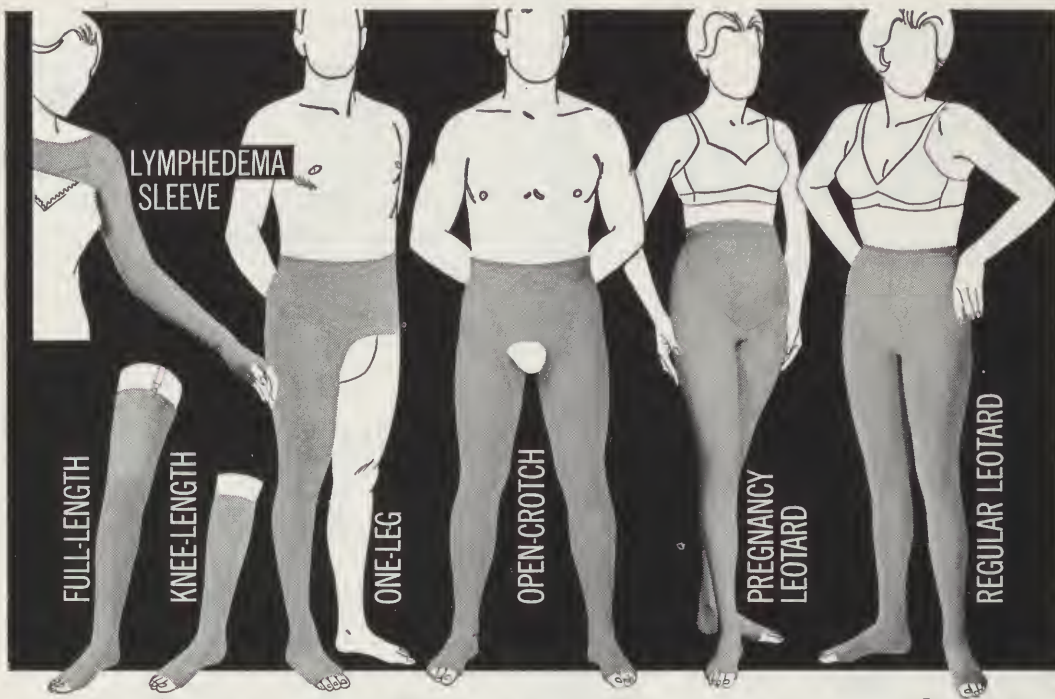


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Camp Glyndon for diabetic children is located on 44 acres of wooded ground in Glyndon Md. We now have 12 beautiful permanent bunk houses in addition to the dining hall, kitchen, infirmary, dispensary, and arts and crafts building.

A handsome Olympic swimming pool, tennis courts, and athletic field contribute to what must be one of the finest camp facilities in Maryland and perhaps in this country.

Our ability to give service to diabetic children is limited only in dining space and scholarships to cover the cost of running the camp.

We are in the midst of erecting a new building, a pavilion which will seat over 200 people and, in addition, will contain a large stage and facilities for outdoor cooking. Since the entrance is only 50 feet away from the present dining room, we can readily serve and feed overflow children in this new area.

When camp resumes in June, we will be in a position to accommodate 200 children for each two-week period providing we can raise the necessary funds to provide scholarships.

The four two-week periods all begin on Sunday. The first one on June 24 is for ages 14, 15, & 16; the second on July 8 is for ages 11, 12, & 13; the third on July 22 is for ages 8, 9, & 10; and the final one on August 5 for ages 5, 6, & 7.

Camp Glyndon is sponsored by the Maryland Diabetes Association and is conducted on a non-sectarian basis without restriction as to race, color, or creed.

We are now in position to accept every diabetic child in Maryland this summer if applications are filed promptly. An application form is printed on this page for your convenience.

WILSON L GRUBB MD, President
Maryland Diabetes Association

AMA Medigredit Plan

An AMA national health insurance proposal that would provide federal income tax credits to help finance the purchase of private health insurance had 130 sponsors in Congress within a week after it was introduced. The Senate number of the bill is S444; the House number is HR2222.

New features of this year's bill are coverage of home health care services, dental care for children, and emergency dental services for all. Coverage against catastrophic illness would be financed by the government for all citizens.

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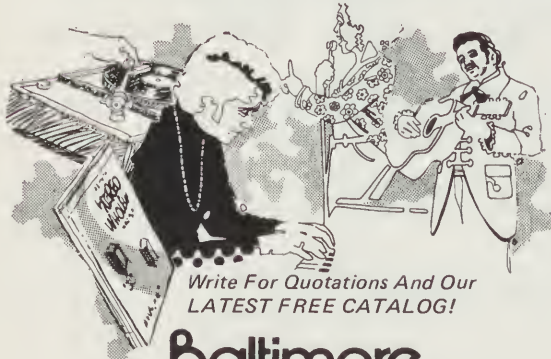
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Physician's Address

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Date

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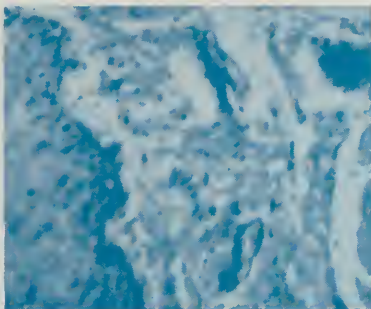


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EDWARD L SHERRER JR MD
Editor

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pathology

ALL YOU WANTED TO KNOW ABOUT BLOOD DONORS BUT WERE TOO BUSY TO ASK

Editor's Note: Several years ago, a Pathology page was a regular Journal feature. With this issue, it has been resurrected. Hopefully, it will appear every other month.

It will be edited by Edward L Sherrer Jr MD, Director of Laboratories, North Charles General Hospital, 2724 N Charles St, Baltimore Md 21218. Related comments, suggestions, or questions should be directed to Dr Sherrer.

The year-end delay in elective surgery in many US cities due to blood shortage was headlined in a recent American Medical News (p 13, 1/15/73). The delay caused an inconvenience to both patient and physician. This blood shortage should cause physicians ordering blood for patients to question why these inconvenient and at times life-threatening blood shortages occur.

The physician tends to prescribe blood (blood as used in this article means whole blood, packed red cells, platelets, and plasma components) as if it was the same as other therapeutics. However, there is a great difference between blood and manufactured drugs. Blood must be obtained from human donors. Too frequently, the busy physician ordering blood does not consider he has a responsibility in donor procurement to obtain this blood. This responsibility is left to the hospital blood bank.

This raises two questions: From where are donors recruited and what induces people to be inconvenienced to give time needed to donate and suffer the discomfort of donation? First, what determines who can donate? Donor qualifications, qualifications established to protect both donor and potential recipient, have been published by the American Association of Blood Banks (AABB) and the American Red Cross blood program. Hospitals belonging to the AABB voluntarily subscribe to these qualifications. Recently, the Maryland State Legislature, upon request of the Maryland State Department of Health and Mental Hygiene, passed a law to regulate blood banks which contains donor qual-

ifications. Now the Federal Food and Drug Administration is considering donor- and blood-bank regulations under provisions of a law enacted by Congress in 1962. This will cover blood used intrastate, interstate transfer of blood already being under regulation. The AABB, through its voluntary inspection and accreditation program, and the Maryland State Bureau of Laboratories and the National Institutes of Health, through their inspection and licensure programs, see that these donor qualifications are adhered to by blood-drawing institutions.

The age-and-health requirements of these donor qualifications are fairly stringent and considerably limit the number of potential donors. Donors must be between 18 and 66 years of age. Health requirements eliminate many, particularly those over 45 years who have a higher incidence of hypertension and disease requiring treatment with certain medications. History of hepatitis permanently excludes a person from donating. **Blood transfusions** or travel to endemic malarial areas are cause for rejection for six months.

What then can induce this limited number of potential donors to give blood? The potential donor population can be divided into voluntary and paid. Voluntary and paid donors were defined in a letter dated Jan 30, 1973 from Dr Robert Langdell, President of the AABB, as follows:

"The voluntary blood donor is a person who meets patient blood needs by donating blood as replacement or in advance of need for himself or others without payment from the collecting facility or other source. A paid donor is one who receives payment from any source for his blood."

One motivation for voluntarily donating is what might be termed humanitarianism. He donates blood because he feels he has an obliga-

tion to his fellow man. To encourage this spirit, President Richard Nixon named January National Volunteer Blood Donor Month.

A large group donates because of an obligation for a "debt" for blood used by a relative or friend. Hospitals generally require replacement of blood on a unit-for-unit basis. To encourage this replacement, a substantial fee is charged for each unit of blood—this does not include processing fees and the donor set. For most this fee is \$50, but the blood bank is more interested in blood replacement than payment of the fee.

A complicating factor in the recruitment of donors to replace blood of medicare patients is that they are obligated to replace only the first three units with medicare paying the cost for all additional units. Also, medicaid pays for all units. This payment by medicaid removes one of the strong motivations for blood replacement and places a particularly heavy burden on blood banks of hospitals with large indigent populations, and therefore covered by medicaid. In 1972 one Baltimore area hospital had a 69% replacement rate by "private" patients, while "service" patients replaced only 14.5%.

Payment is still another motivation for donating. Payment is defined by Dr Langdell as follows:

"Payment shall include money or other compensation which can be converted to money by the recipient. Payment to a third-party individual or organization, regardless of whether that payment is made by the blood-collecting facility or any other party, shall constitute payment for the blood. The following shall not constitute payment for blood donation: cancellation or refund of the nonreplacement fee or related blood transfusion charges."

Voluntary blood donors are generally preferred over paid because, in spite of more sensitive laboratory methods for the detec-

tion of diseases transmitted by transfusion, especially hepatitis, an accurate history is still the best screen to eliminate the danger of transmitting these diseases. Those expecting payment for their blood have greater reason to conceal a history of these diseases than does the volunteer.

In spite of these motivations, blood shortages still exist. To expand the voluntary donor pool in the Greater Baltimore Area and thus hopefully reduce or eliminate blood shortages, a Blood Assurance Group has been established by the Maryland Society of Pathologists in conjunction with the Maryland Blood Exchange of the AABB and the Baltimore Regional Red Cross Chapter.

The objective of this program is to motivate potential individual donors to protect themselves and relatives from future blood needs—planned blood protection. This plan is well explained in an Oct 13, 1972 letter to Baltimore metropolitan physicians from Dr Bradley King Jr, President, Maryland Society of Pathologists, and the brochure enclosed with the letter. (Additional brochures may be obtained from Dr Bradley King, Maryland General Hospital, Dept of Pathology, 827 Linden Ave, Baltimore Md 21201.) Much effort over the past ten to 15 years has gone into this unprecedented cooperative plan. The Assurance Group finally became a reality largely through the efforts of Drs John Petrucci and Selvin Passen of the Blood Bank Committee of the Maryland Society of Pathologists. If you have any questions about this program, the pathologist at any of the participating hospitals will be glad to answer them.

The Assurance Group is now in being. It gives the people of the Greater Baltimore area a convenient method of planning ahead for possible blood needs as individuals at the hospital of their choice. The Maryland Society of Pathologists and the Assurance Group hope the Baltimore area physicians will take an interest and support this vital program.

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Each March Membership Awards are given at the AMPAC Workshop in Washington. We thought you might be interested in knowing more about these awards.

AMPAC Membership Awards are divided into the following categories: 1) Total Contributions (largest membership treasury), 2) Contributions Per Member (highest average contribution), 3) Ratio of Members to Potential (each physician is a potential PAC member), 4) Total Women Members (highest number of women members), and 5) Largest Increase Over Prior Year (largest increase of total members). The sixth category is the cumulation of all five categories and is entitled All Events.

Last month at the AMPAC Banquet, awards were given to many proud PACs. The California PAC placed first in the Total Contributions Category and second in the Increase Over Prior Year Category. Illinois placed second in Total Contributions, while Pennsylvania was third.

The Idaho Medical Political Action Committee won first place in the category of Contributions Per Member. The District of Columbia placed second in this category and South Dakota third.

Alaska was awarded first prize in the category of Ratio of Members to Potential. New Mexico ranked second and Oregon third.

First place in the category of Total Women Members was won by Indiana, while Kentucky ranked second and Kansas third.

Florida PAC was the only one to achieve two first-place awards. The categories were Largest Increase Over Prior Year and All Events. California placed second, and Texas won third place in Largest Increase Over Prior Year. Texas also was awarded second place in the All Events category. Finally, third place in All Events went to Oregon.

Maryland has never won any of these awards. Isn't it about time we stepped up our membership efforts? There are approximately 4,500 physicians in Maryland, and each one is a potential PAC member. And each physician's wife is a potential PAC worker and contributor. If you are now a member of MMPAC, make it your responsibility to recruit one new member. If you are not a PAC member, join now! And be sure your wife joins with you!

It is not too soon to anticipate our role in the 1974 elections. There will be a gubernatorial race that year and a senatorial contest in addition to the congressional races. Our participation in these campaigns is vitally important. Our participation will be more effective in proportion to how much we can increase our membership.

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A copy of MMPAC's report, filed with the appropriate supervisory officer, is available for purchase from the Supt of Documents, US Govt Printing Office, Washington DC 20402.



ROBERT E FARBER MD MPH
Commissioner

Baltimore City health department

BALTIMORE'S HEALTH IN 1972

A sharp drop in resident births in Baltimore City and a record low in infant deaths were the most dramatic events in Baltimore's public health picture for 1972.

Heart disease, cancer, and strokes (7,012 of 10,914 deaths) were the three leading killers in 1972. These were followed by accidental causes, cirrhosis of the liver, and diabetes—another 1,232 deaths. The leading causes show little change over 1971. A significant difference may be noted with the year 1900 when the three leading killers were pneumonia, tuberculosis of the lungs, and infant diarrhea. The major differences reflect improved therapies and improved health and environmental practices. On the other hand, deaths from heart disease (4,176), cancer (2,035), and stroke (801) are believed to be the result of hypertensive living and lack of attention to cancer's danger signals and the danger in excessive cigarette smoking. The World Health Organization—together with the medical profession and federal, state, and local health agencies—will soon launch an attack on the leading ills of modern times with the biggest effort going to the prevention and treatment of cardiovascular disease.

The preventable communicable diseases are at their lowest ebb in Baltimore's history. The record shows only three cases of measles reported, six cases of whooping cough and 23 cases of rubella. There has been no case of smallpox since 1928, no case of human rabies since 1930, no diphtheria since 1964, and no polio since 1967.

Only eight Baltimore children have been clinically diagnosed with lead paint poisoning—the lowest on record. However, the report notes an additional 218 children found with elevated blood lead but no obvious symptoms. While the city's control work in this field goes back many years, a newly received federal grant of \$150,000 for the first year of a three-year proposal for lead

detection and prevention will help determine the prevalence of this silent epidemic in Baltimore and protect children from the consequences of poisoning.

Mid-1972 saw the opening of the Cherry Hill Multipurpose Complex. This new million-dollar facility constructed in about a year's time is now providing badly needed health and social services including mental health and drug abuse clinics for a wide area of South Baltimore housing approximately 50,000 residents.

Added services to the elderly ill were made possible through assistance by the Maryland State Department of Health and Mental Hygiene early in the year. This financial aid enabled the expansion of transportation and escort services of the needy aged to physicians and clinics. Overall, 9,000 elderly persons are now being aided by this bureau with a variety of services including home visits, telephone surveillance, and general assistance with social and community services.

Meeting an increasing threat of rabies from the bat population, the City Health Department in June gave antirabies vaccine to 7,824 pets, chiefly dogs. This was part of a state-wide effort sponsored by state and local health departments and veterinarians.

1972 saw a 33% upswing in infectious syphilis and a leveling off for the second consecutive year in the number of cases of gonorrhea reported to the Health Department. Infectious syphilis cases reported numbered 600 compared to 447 in 1971; gonorrheal infections totaled 11,300 compared to 11,006 in the previous year. In the latter disease a specially funded federal project is finding asymptomatic gonorrhea in significant numbers of women attending 27 cooperating hospitals and clinics. By year's end 250,000 gonorrhea cultures had been taken of Baltimore women in this intensive case-finding project that

began in June 1968.

A crash program in Baltimore schools by Health Department physicians and continuing public programs by the media are helping to alert the public at risk to VD. In a world of growing sexual freedom, the serious effects of syphilis and gonorrhea will remain a threat to the unsuspecting until such time as a preventive vaccine may be developed.

Tuberculosis, for many years a leading cause of death and disability, continues a downward trend. Baltimore no longer has the unenviable position of first among the large cities in new cases. It now is outranked by two other large cities in the country. The past year saw 66 tuberculosis deaths compared with 72 in 1971 and 424 active cases compared with 458.

While Baltimore has maintained high immunization levels in children for diphtheria, whooping cough, tetanus, polio, measles, and rubella, the new State Regulations for the inoculation of school children (effective Jan 1, 1973) should reduce these diseases to the absolute minimum.

Baltimore's medical care needs and drug abuse remain major public health concerns. Progress, however, is being made through newly established health care centers and group practices. Among those opened in 1972, or in the process of becoming functional, were the Mercy-Southern Health Center for children and teen-agers of South Baltimore, the West Baltimore Community Health Organization, Homestead-Montebello Community Health Center, and the First Maryland Health Care Corporation.

On the drug abuse front, the coordination of treatment, education, and rehabilitation services by a special Office of Drug Abuse Control, established in December as an administrative unit of the Mayor's office, hopefully will serve to marshal the necessary forces to bring this health problem under control. Financial support has been received through \$225,000 in federal and state grants.

Population

The estimated resident population of Baltimore City as of July 1, 1972 was 881,000 persons with 446,000 white residents and 435,000 nonwhite residents. This represents a decline of 16,000 persons when compared with the July 1, 1971 estimated population of 897,000 persons.

Between July 1, 1971 and July 1, 1972 approximately 3,300 persons were added to the population through natural increase while an estimated 20,000 residents were lost as the result of migration. In the white population deaths again exceeded births, resulting in a natural decrease of 880 persons. Among the nonwhite population

natural increase added approximately 4,200 persons, 2,300 fewer than in the previous year. During the 12-month period since July 1, 1971 the estimated net outmigration of white residents amounted to 17,900 persons; in the nonwhite population there was an estimated net outmigration of 2,100 persons.

Births

The estimated number of resident live births during 1972 was 13,181. This represents a decline of 1,889 births, or 12.5% when compared to the 15,070 births registered during 1971. For 1972 the birth rate, the number of births per 1,000 city residents, was 15.0 or 10.7% below the 1971 rate of 16.8.

The declines in the number of births and the birth rate began in 1958 and have continued to the present. Since 1957, the year in which the number of resident births was greatest, the number of births has declined 11,886 births (47.4%) from 25,067 in 1957 to 13,181 in 1972; the birth rate has declined 40.9% from 25.4 in 1957 to 15.0 in 1972.

Deaths

There were 10,914 resident deaths reported in 1972, 70 more than the 10,844 reported in 1971. The resident death rate per 1,000 population increased from 12.1 in 1971 to 12.4 during 1972.

Infant deaths, deaths of children under one year of age, numbered 269 in 1972. For 1972 the infant mortality rate per 1,000 live births was 20.4 or 18.4% below the rate of 25.0 recorded during 1971. The 1972 provisional rate of 20.4 is the lowest rate ever recorded in Baltimore. In 1972 there were four maternal deaths, one less than the five recorded during 1971, another record low.

The gap between death rates of nonwhite infants and death rates of white infants has been narrowing and is now half of what it was ten years ago. The following table compares white and nonwhite infant mortality rates.

	Infant Mortality Rate (Deaths under one year of age per 1,000 live births)		
	Total	Nonwhite	White
1962	32.9	40.8	25.3
1971	25.0	29.1	18.7
1972	20.4	23.6	15.6

Although infant mortality rates reflect many social and economic factors of society, it is our opinion that such trends have been precipitated and reinforced by better medical services being made available and used by pregnant women and new mothers. These services are increasingly available to that segment of the population

that previously did not have access to them. In view of the fact that the City Health Department's Child Health Services' programs are directed largely at inner-city women, pregnant women, and young children, the trends demonstrate some of the effectiveness of the Maternal and Infant Care Project 501, the Children and Youth 606 projects, and Family Planning Project 722.

For the leading causes of death, the 1972 figures are as follows: heart disease, 4,176 deaths, down 10 from 1971; cancer, 2,035, up 40; cerebrovascular disease, 801, up 13; accidents, 442, up 33; cirrhosis of liver, 409, up 77; diabetes mellitus, 381, up 58; homicide, 361, up 28; influenza and pneumonia, 265, up 19; congenital malformations and diseases of early infancy, 205, down 93; and suicide, 102, down two.

Comments

Assessing the city's health, the Commissioner has noted that the infant mortality rate is a main indicator of a community's health status. It reflects many factors including the availability and accessibility of health services, the hygiene of housing, nutrition, crowding, and parental health knowledge. It is evident from this year's report that Baltimore's health status is at a new peak. Its infant mortality, while not the lowest of all US large cities, is among the best of the most populous cities and is a remarkable improvement over that of Baltimore's 1962 record and especially so when the nonwhite infant death rates are considered.

Evaluating the impact on the city of the decline in births, the Commissioner indicated that this will result in significant changes for both residents and city government. Economically, many families will experience a lessening of the pressures for housing, clothing, and rearing children. Households should be more manageable.

On the other hand, the declining birth rate, or one stabilized at the current level, should eventually produce declines in school population and a significant lessening of demands on all public services. Such a consequence should enable the city to redistribute the tax dollar to meet future changing needs. In so far as the City Health Department is concerned, this presupposes the continuation of federally-supported health programs.

Baltimore's future health—its physical, social, and mental well-being—looks bright indeed. The new Baltimore is no longer over the horizon. It is here and growing. The ensuing 70s should see a continuing maturation of today's plans and work.

The latest news in weight control is still the good, balanced diet—but less.

"Perhaps two-thirds of our people should go to bed hungry every night." The nutritionist who made this statement recently was not being inhumane. Rather, he was suggesting that many Americans would do well to deprive themselves of such institutions as the second helping and the midnight snack.

For many overweight persons the answer is not a "crash" program but a "crack-down" on the quantity and quality of food eaten. Sound advice for dieters remains: Follow a good, balanced diet and wage war against bad eating habits. To lose weight, eat less.

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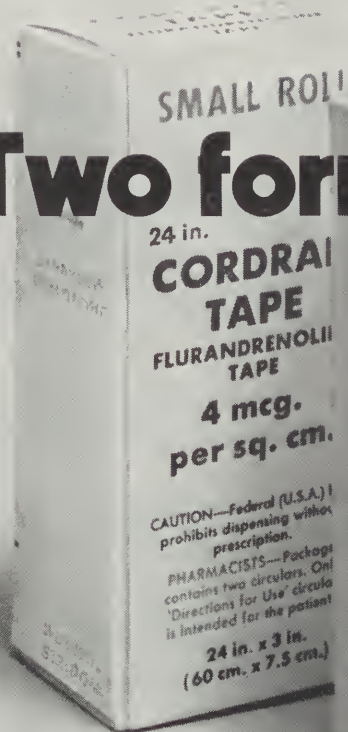
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ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES: DIAGNOSTIC IMPLICATIONS AND LIMITATIONS

JOSEPH GOODGOLD MD

Director, Research and Training

Department of Rehabilitation Medicine

New York University Medical Center

400 E 34th St, New York, NY 10016

This paper, coauthored by Dr Arthur Eberstein, the William Royal Stokes Memorial Lecture, was delivered at the 174th Annual Med-Chi Meeting in Baltimore, May 5, 1972. Information and reprint requests to Dr Goodgold.

While it is true that several years of formal training are required to qualify as a serious electrodiagnostic expert, from a pragmatic viewpoint, a major consideration in electromyography and nerve conduction studies concerns the significance and interpretation of data. From a technical viewpoint, the avoidance of error and its incident misinterpretation is of equal importance.

When is electromyography useful? Fundamentally, it is a means of assisting in the clinical evaluation which frequently permits a certain degree of quantification—eg, conduction velocity determinations. A patient with peripheral neuropathy is likely to show a conduction rate of 30 meters/sec rather than 60; if treated successfully, the value may go up to 40, to 50 and then to 60 meters/sec. Certainly, serial studies complement therapeutic evaluation.

To the practitioner, electromyography is of value in consideration of motor and sensory disorders involving the neuromuscular system. If a patient has weakness, paralysis, or atrophy, electromyography may be helpful in arriving at a specific diagnosis. Such motor problems as fasciculation contractions, rigidity, or abnormal types of cramping also lend themselves to considerable help from electrodiagnostic studies.

Sensory disturbance, such as paresthesias, anesthetics, and pain, are complaints which can frequently be elucidated by EMG and conduction determinations.

A review of problems of weakness which frequently are encountered by the clinician is presented in Table 1. Diminished motor power is one of the commonest complaints investigated in the electrodiagnostic laboratory. As a take-off point one must differentiate lassitude or a feeling of weakness from actual weakness. Lassitude is frequently associated with psychosomatic disorders.

Table 1: Diseases in which Weakness May be a Cardinal Symptom

Infectious Diseases	Myopathy
Tuberculosis	Progressive muscular dystrophy
Brucellosis	Thyroid myopathy
Parasitic diseases	Myasthenia gravis
Hematopoietic Diseases	Myotonia
Severe anemia	Familial periodic paralysis
Toxic Diseases	Neuropathy
Uremia	Localized lesions
Heavy metal poisoning	Peripheral nerves
Botulinum toxin	Roots
Alcoholism	Spinal cord
Neoplasms	Brain
Myopathy or neuropathy secondary to carcinomatosis	Generalized
Metabolic and Endocrine Diseases	Chronic motor neuron disease
Thyrotoxicosis	Charcot-Marie-Tooth disease
Diabetes	Dejerine-Sottas disease
Porphyria	Polyneuropathy of various etiologies
Glycogen/lipid storage disease	Collagen Diseases
Psychoneurosis or Psychosis	Rheumatoid arthritis
Hysterical paralysis	Dermatomyositis/polymyositis
	Periarteritis nodosa

(From J Goodgold and A Eberstein, Clinical Neurophysiology in the Evaluation of "Weakness," Med Clinics of No Amer, 53:626, 1969.)

Usually the infectious diseases are rather acute in onset and the associated weakness generally ceases after recovery. Tuberculosis and brucellosis, however, are examples of infectious processes which may be associated with long-term weakness.

Neoplasm is a well-known cause of weakness, being associated with general debility and neuromyopathies. Primary myopathy, or neuropathy, as well as some of the diffuse neuropathies like chronic motoneuron disease, Charcot-Marie-Tooth, etc are also indicated in the tabulation.

It is in the categories of myopathy, neuropathy, collagen diseases, metabolic disorders, neoplasm, and toxic disease that some definitive evidence may be found during the electrodiagnostic examination.

What is Electromyography?

Electromyography is the detection and recording of electrical activity from muscle. It is a well-known fact that action potentials are generated during muscular contraction. However, these potentials are very small in amplitude and must be considerably amplified to be observed and recorded. Thus the first requirement after the potentials are detected by an electrode either inserted or placed over the muscle is an ampli-

fier which will amplify and faithfully reproduce the muscle action potentials. After amplification, the voltages may be displayed and observed.

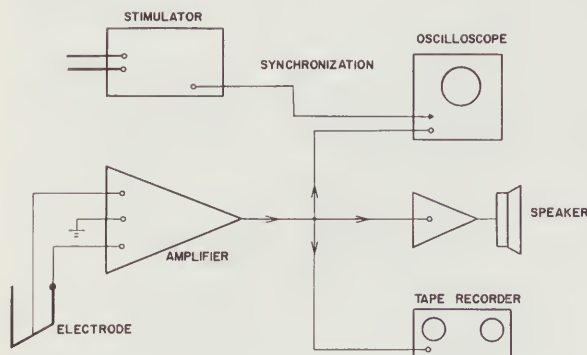


Fig 1: Diagram showing basic components of electromyograph.

Fig 1 is a diagram showing the basic components which make up a typical electromyograph. The electrodes are connected to an amplifier and the output of the amplifier connected to different monitoring devices: 1) an oscilloscope to permit immediate display and visual monitoring of the potentials; 2) a speaker to allow acoustic monitoring of the potentials; and 3) a tape recorder to make a permanent record of the observed potentials.

The electrodes and electronic equipment must be carefully designed to faithfully reproduce the physiological event and present this to the observer without distortion and free of interference.

For nerve conduction measurements, it is necessary to include a stimulator synchronized with the oscilloscope to permit stimulation of nerve and/or muscle.

EMG Patterns

Under ordinary circumstances, a skeletal muscle of a human is electrically silent at rest. This state is disturbed by the insertion of the needle electrode whose point mechanically stimulates and injures some of the muscle fibers. The electrical disturbance which is created in this way is quite normal and is called insertion activity. It consists of a series of sharp spikes which last for a very short interval of 300-400 msec ($1 \text{ msec} = \frac{1}{1000} \text{ second}$). When the muscle

is relaxed, the cathode ray oscilloscope baseline is flat and the loud speaker is silent.

In patients with some neuromuscular disease, whether it be a primary myopathy (muscle dys-

trophy) or a primary neuropathy (amyotrophic lateral sclerosis), insertion activity is markedly prolonged. It is significant in demonstrating the existence of abnormality but is diagnostically nonspecific. It may be seen in patients under renal dialysis who develop electrolyte disequilibrium or in patients with muscle denervation due to poliomyelitis.

After insertion activity has been observed, the subject is asked to slowly contract his muscle. The electrical potential which is recorded is usually of a triphasic or biphasic form and is called the motor unit action potential. These discharges are regular in rate and rhythm. When the volitional effort of contraction is increased in intensity, the motor units increase their rate of firing and more motor units are recruited. Therefore, gradation of contraction involves increasing the total number of motor units while their rates of discharge change from about five per second to about 50 per second.

At maximal contraction, myopathic and neuropathic diseases can be differentiated. Amyotrophic lateral sclerosis may be used as an example of neuropathic disease in which motor cells are destroyed. The ability to recruit is seriously compromised so that at maximal contraction, individual motor unit action potentials can still be identified. This "single unit pattern" is characteristic of neuropathic disease and can be seen, for example, in Polio, Charcot-Marie-Tooth disease, and Guillain-Barré disease.

If comparison is made to an individual whose complaints of weakness are due to progressive muscle dystrophy, what is the difference?

The patient with muscular dystrophy has lost muscle fibers but not anterior horn cells. Hypothetically, if one anterior horn cell originally innervates 100 muscle fibers and 50 are destroyed, slight movement of an extremity might require recruitment of two motor units rather than just one. The dystrophic individual recruits his motor units more quickly and fires them more frequently so that even with a small contraction there is a complete interference pattern, ie, no baseline can be identified on the oscilloscope monitor. A total interference pattern with small contraction is characteristic of myopathies.

Fibrillation action potentials occur spontaneously. They are frequently associated with increased insertion activity and another type of potential called positive sharp waves. By convention and tradition, in electrophysiological recording an upward deflection is negative in sign.

These spontaneous electrical changes occur in diseased muscle when membrane stability is disturbed; most usually, but not exclusively, they are associated with neuropathy. As a matter of fact, up to some ten or 15 years ago, fibrillations were considered pathognomonic of lower motor neuron disease. We know now that there are many patients with myopathy whose muscles show these potentials; they are particularly frequently encountered in polymyositis.

Polyphasic potentials may be divided into two groups: one relatively greater in amplitude and duration which is associated with neuropathies, and the other, associated with myopathies, rather small. In polio, the polyphasic potential may last 20 or 30 msec compared to that seen in myopathy which last five to ten msec.

Clinical Problems

Radiculopathy

Radiculopathy is one of the most frequent diseases in which electromyography may be of notable assistance in solving a problem of pain and/or weakness in the leg or arm.

For example, when electromyographic examination is carried out in identification of lumbosacral disc disease some of the following electromyographic findings may be recorded: increased insertion activity, increased polyphasic potentials, fasciculation potentials, bizarre discharges, fibrillation, and positive sharp waves. Some combination of these electromyographic abnormalities would be significant.

The identification of a radicular distribution is not difficult. Muscles that have a common root distribution (a common myotome) but are innervated by different peripheral nerves must be identified. For example, with abnormalities in the anterior tibial, the extensor hallucis longus and the extensor digitorum brevis, the common innervation is the peroneal nerve. Under those circumstances of restricted information, it would not be possible to positively identify the lesion as a root problem or peripheral neuropathy (eg, crossed leg paralysis).

However, if the peroneus longus is examined (the peroneal nerve) as well as the tibialis posterior (tibial nerve) and the tensor fasciae latae (superior gluteal nerve), and all of them show abnormal electromyographic findings, then the only common denominator would be a defect of the L₅ root distribution.

What are some of the problems with electromyographic diagnosis of root disease? Electromyography cannot achieve the task of pinpointing anatomical specificity; it can only reveal

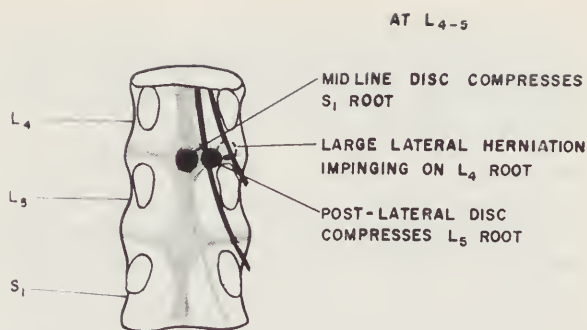


Fig 2: Specific location of disc herniation and root affected. Midline disc affects S₁. Moderate sized post-lateral herniation impinging on the usual L₅ root while large lateral herniation compresses L₄.

root dysfunctions. Fig 2 helps to clarify this principle. At the L₄₋₅ interspace, the usual disc herniates post-laterally to impinge on the L₅ root; with midline protrusions, then L₄, L₅ might be spared but S₁ affected. Electromyography, therefore, identifies a functional rather than an anatomical level of involvement. If a patient is scheduled for surgery, it is wise to complement the electromyogram with myelography so as to determine the exact site. The new therapy of injection of discs with proteolytic enzymes based on EMG alone is a fallacious approach.

Electromyography may be used to differentiate radiculopathy from plexitis or peripheral nerve lesions. If the lesion is distal to the posterior primary division of the spinal nerve, the paraspinal muscles will be spared. On the other hand, with a root lesion as traumatic evulsion due to excessive stretch, the paraspinal muscles will show EMG abnormalities. It is also helpful to note that abnormal electrical findings in the back muscles precede those in the extremities by eight or ten days, permitting earlier objectification in acute disc herniations.

With regard to weakness, the usefulness of electromyography may be documented by three illustrative cases:

Case #1

An infant who looked relatively normal at birth progressively became hypotonic. The child was a member of a family with Pompe's disease which involves an alpha 1-4 glucosidase deficiency that profoundly affects glycogen breakdown and accumulation. In these children accumulation is predominantly in skeletal muscles, spleen, and heart. With this child, the clinical diagnosis was first made by the pediatric cardiologist who detected cardiomegaly associated with both right and left heart preponderance in the EKG.

The electromyographic findings in the muscles of the leg consist of continuous spontaneous electrical discharges—positive sharp waves and fibrillation potentials.

Case #2

Here again the electrophysiological disturbance is detected by electromyography instead of conduction studies. A 12-year-old male complained of muscle stiffness since his childhood. His father had the same problem. His disability was characterized by an inability to relax his muscles. When asked to close his eyes, for example, it was difficult to open on command; when he shook hands he couldn't release on command. Potentials which were identified as myotonic responses persisted after the voluntary contraction. They showed an oscillation of amplitude and frequency associated with a characteristic waxing and waning sound (similar to a diving aircraft!).

Case #3

A 21-year-old patient was referred with a diagnosis of scapulohumeral muscular dystrophy. As soon as the needle electrode was inserted myotonic discharges were detected. Short duration motor units and polyphasic potentials were also present. The diagnosis, therefore, was myotonic dystrophy. The outlook with regard to longevity and complications are quite different when comparison is made between myotonia and scapulohumeral muscle dystrophy.

In review, electromyography may be used to detect electrical changes in the muscle. Conduction studies are used to detect conduction defects in both motor and sensory nerve fibers as well as at the neuromuscular junction.

The simplest examination of nerve conduction may be carried out with stimulation of a nerve with electrodes placed on the overlying skin (Fig 3). The test is accurate and easy to perform. Considerable information is gained by careful visual observation of the responsive muscles. Obviously, if a nerve is stimulated and no response occurs it is reasonable to conclude that this patient has a disturbance of conduction somewhere in the neuromuscular axis.

Conduction velocity determinations are demonstrated in Fig 4. It can be seen that with the median nerve, recording electrodes are placed over the muscles of the thumb and that stimulation is made at two points, at the elbow and at the wrist. The distance between the two points is measured. In the recording, the time required to traverse this distance is calculated. Thus, with time and distance known, a con-

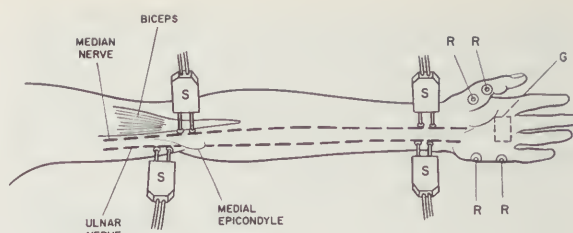


Fig 3: Drawing of arm indicating relation of median and ulnar nerves and positions of stimulating electrodes (S) at the wrist and elbow. Recording electrodes (R) are shown in position for recording the responses to median and ulnar nerve stimulation. The ground electrode (G) is on back of hand.

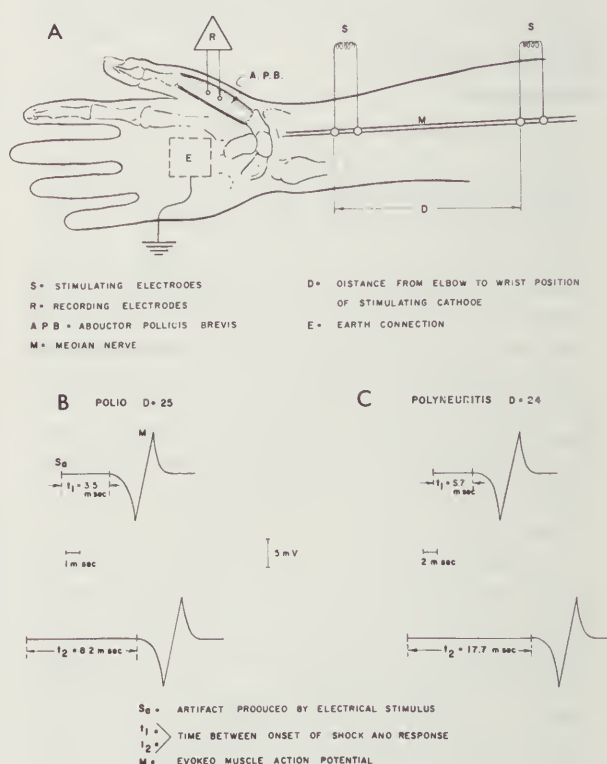


Fig 4: Recording conduction in motor fibers. A, Diagram of method to record motor conduction velocity of the median nerve in the forearm. Stimulation is made at two percutaneous points along the nerve, at elbow and wrist. The recording electrodes are placed on the thenar eminence over the belly of the abductor pollicis brevis. The distance D between the two sites of stimulation is measured along the surface of the forearm. B and C, Oscilloscopic recording in patients with polio and polyneuritis, respectively. The time required to traverse the distance D is equal to (t₂ - t₁).

Conduction velocity (CV) = Distance/Time. In polio, the CV = $\frac{25 \text{ cm}}{(8.2 - 3.5) \text{ msec}} = 53$ meters per sec. In the patient with polyneuritis, CV = $\frac{24 \text{ cm}}{(17.7 - 5.7) \text{ msec}} = 20$ meters per sec.

duction velocity for that segment of the nerve may be easily calculated.

In this illustrative case, the problem involved differentiation of poliomyelitis and polyneuritis. In poliomyelitis, the conduction velocity is normal because axons which remain intact are normal; whereas, in polyneuritis, the lesions of segmental demyelination affects the conduction which may drop from 53 meters/sec to 23 meters/sec. The difference between the two diseases is appreciable.

Most clinicians can differentiate Guillain-Barre disease from polio, but occasionally it is a most difficult task, especially if the spinal fluid protein changes are not obvious. Under these circumstances conduction studies can help make a rather quick evaluation. In over 50% of the cases of Guillain-Barre disease (infectious polyneuritis) the conduction rate will be profoundly affected.

In Fig 5 the method of detection of impulse conduction defects in the sensory fibers is shown. The digital nerves are stimulated with ring electrodes on the finger and the response is recorded at the wrist. The shock artefact is due to the stimulus.

The effect on nerve conduction of various lesions is shown in Table 2. If there is a mild demyelination, perhaps due to compression, then there may only be a delayed conduction of the sensory nerve action potential. In advanced demyelination, both sensory and motor fiber conduction is delayed and the amplitude of the evoked response will be diminished. If both demyelination and axonal degeneration are involved, a considerable delay in conduction and a marked drop in the amplitude of the response ensues. With total axonal degeneration, (eg, in facial nerve involvement where the compression has been severe enough to cause complete Wallerian degeneration) stimulation of the nerve will not evoke any muscle action potentials.

Table 2:	
Degree of Involvement	Effect on Conduction
Mild demyelination	Delayed conduction of the sensory nerve action potential. Slight diminution of amplitude of the motor response.
Advanced demyelination	Delayed conduction in sensory and motor fibers. Moderate reduction of amplitude of evoked response.
Demyelination + axonal degeneration	Considerable delay in conduction and greater attenuation of the evoked response.
Total axonal degeneration	No conduction.

(From J Goodgold and A Eberstein, *Electrodiagnosis of Neuromuscular Diseases*, Williams & Wilkins, Baltimore, 1972 p 158.)

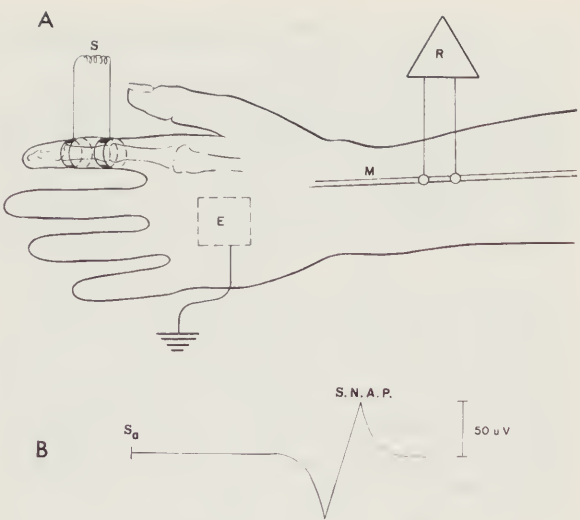


Fig 5: Recording sensory nerve action potential. Sensitivity of the instrumentation must be considerably improved to record the voltages of sensory nerve action potentials, which range from 10 to 50 microvolts as compared to the 5 to 10 millivolt range of the muscle action potential. A, Placement of electrodes. B, Recording of a sensory action potential from the median nerve at the wrist after stimulating the digital nerves of the index finger.

One of the most common problems in which conduction studies are useful occurs at the wrist and involves the median nerve as it passes down into the hand under the transverse carpal ligament—the carpal tunnel. A recurrent twig of the nerve comes around to innervate the thenar muscles. If the nerve is stimulated at the wrist the length of time will be increased for the impulse to cross the compressed segment. It normally takes 3.5 msec; in the patient with carpal tunnel disease, it may take six, eight, or ten msec.

The ulnar nerve does not go through the carpal tunnel but passes under the volar carpal ligament to a distal point where it hooks around the hamate bone. In this region it goes through Guyon's canal and is subjected to the same type of a compression as the median nerve in the carpal tunnel. The most frequent compressive lesion is a ganglion. There may be slowed conduction of the ulnar nerve involving the sensory distribution to the fifth digit, or to the muscles innervated by the ulnar nerve's deep branch which crosses over to the dorsal interossei, or both.

There are many technical problems which may be encountered in doing conduction studies. The occurrence of anomalous nerve connections is a frequent source of confusion; per-

haps anomalies are more to be looked for than a so-called normal pattern.

One of the commonest variations involves a few strands of nerve which pass between the median and ulnar in the forearm. This cross-over is present in at least 30% of normal humans. Another anomalous type of distribution involves the extensor digitorum brevis muscle of the foot which is "normally" innervated through the deep branch of the peroneal nerve. In this case there is an accessory branch originating from the superficial peroneal nerve which goes around the lateral malleolus to innervate the short toe extensors. If conduction studies of the deep peroneal nerve are performed because of a crossed-leg paralysis, sparing of the superficial peroneal portion with an accessory deep peroneal branch may cause a most perplexing picture.

One method to avoid the puzzle and recognize anomalies in the hand, for example, is to simultaneously record from the hypothenar and thenar muscles after simultaneous stimulation of median and ulnar nerves.

In Fig 6 it can be seen that the patient has had some degree of degeneration involving the ulnar nerve throughout its entire length. With stimulation of the ulnar nerve at the elbow, there is no response because none of these fibers are intact. If the median nerve at the elbow is stimulated there will be response in the hypothenar muscle due to fibers which crossed over. When the ulnar nerve at the wrist is stimulated, there is response again because of the fibers that have crossed. When the median nerve of the wrist is stimulated there will be no reaction. If these four steps are carried out it is at least possible to rouse a suspicion of anomaly. In some cases, only a portion of the muscle may be so innervated; if supramaximal stimulation at the elbow, for example, results in a response which is twice as big as that evoked at the wrist, the examination must include investigation of anatomical variants.

Myasthenia

The myasthenic response is obtained with repetitive stimulation rather than the single shocks used in conduction velocity studies.

In myasthenia gravis the amplitude of the first response is normal. As activity is continued the patient may become paretic and the amplitude of the successive responses decrease. A short-lived recovery and augmentation in amplitude is characteristic and due to the phenomenon of facilitation.

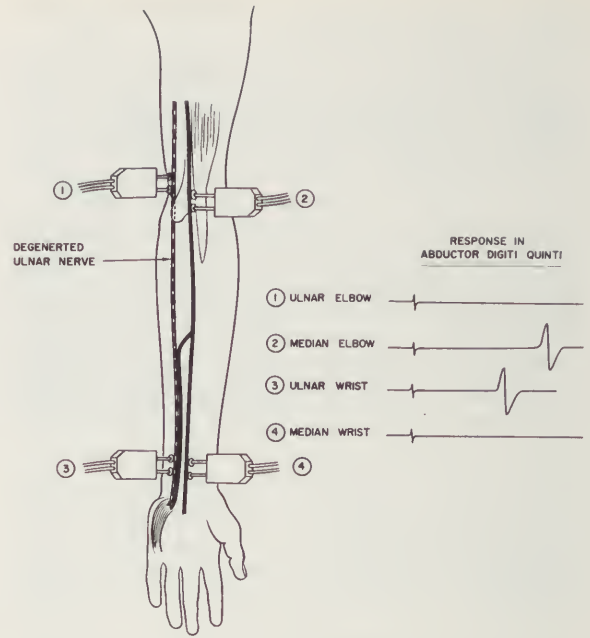


Fig 6: Scheme for detection of anomalous cross-over from median to ulnar nerve in forearm when a complete ulnar neuropathy exists.

In Fig 7 the upper test shows three superimposed responses. If each response were of the same amplitude all would fall into a single line tracing. With decrementation, however, each recorded potential will show the peak of its negative deflection at a lower level. The three responses in Fig 7-A demonstrate the progressive failure of transmission characteristic of myasthenia gravis.

Myasthenic responses associated with weakness are also seen in patients with pulmonary carcinoma, that is, the "myasthenic syndrome." The two diseases may be differentiated electrophysiologically. In the syndrome the initial response is extremely small (Fig 7-B), while in myasthenia gravis the first response is normal. After a period of exercise (eg, 30 sec), the patient with myasthenia gravis shows facilitation of about 10% to 20%, while in the myasthenic syndrome, facilitation of 200% or 300% occurs. After a few minutes, both patients develop post-exercise exhaustion. The myasthenia gravis will show a greater defect than present originally and will take about 20 or 30 minutes for complete recovery to the pretest level. The patient with the myasthenic syndrome will also show post-exercise exhaustion, but again it is extreme in degree compared to myasthenia gravis. The two are compared in Fig 7-A and 7-B.

Clinically the two disease entities may be extremely difficult to differentiate with a common complaint of weakness. In the syndrome the malignant lesion may be an occult one; chest X-ray is mandatory if the workup is to be complete.

Public Confidence

Medicine still leads all other institutions in public confidence ratings, a 1972 Harris Survey revealed. Forty-eight percent of the respondents expressed "a great deal of confidence" in the leadership of medicine, but that reflected a sharp decline from a year ago when the figure was 61%. It was 72% in 1966.

Medicine previously had appeared "to be immune from the tide of disenchantment that had swept over most other leadership groups," Harris commented. Financial leaders placed second in the public esteem with a 39% "great deal of confidence" rating. Held in the lowest regard among the 16 groups covered by the survey were advertising (12%), labor (15%), television (17%), and the press (18%).

Beall Foresees Passage of Health Care Legislation

The Honorable J Glenn Beall Jr, junior US Senator from Maryland, in delivering the recent 12th Annual Blessed Mother Seton Memorial Lecture to the medical and administrative staffs of Baltimore's St Agnes Hospital, said that the 93rd Congress appears ready to act on his legislation to improve the delivery of health-care services to the American people.

"I am convinced that our success in solving the health care crisis will depend to a great extent on our ability to improve our delivery system," the Maryland Republican told the 250-member group.

"American medical science and medicine at its best is unequaled anywhere in the world, but the problem is that we have not been able to deliver to our citizens the quality of medical care that we are capable of providing," Senator Beall declared.

"For a variety of reasons—costs, inadequate financing, and manpower shortages—the fact that emerges is that for many Americans, medical care is not available, accessible, or affordable," the Senator said.

Senator Beall's legislation authorizes a total of \$580 million over a three-year period to support the activities of a new National Institute of Health Care Delivery (NIHCD), first proposed by him in the 92nd Congress.

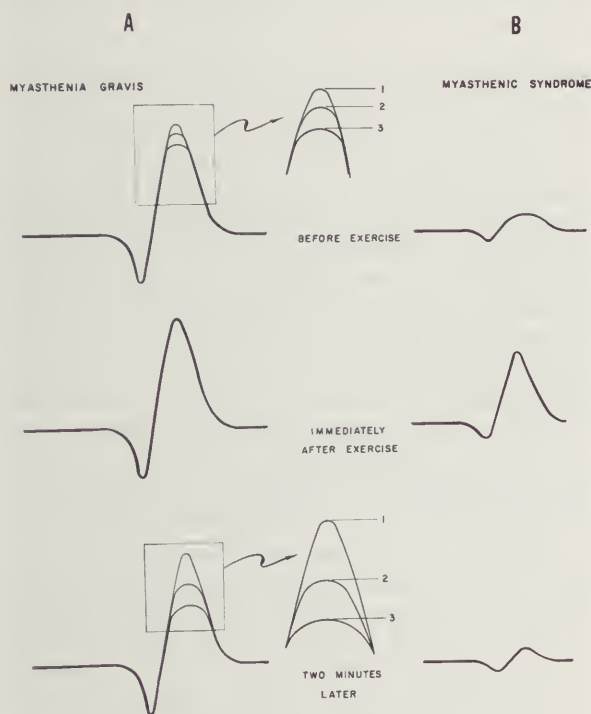


Fig. 7: Studies in patients with myasthenia gravis are shown in the left-hand column. At the top, 3 superimposed tracings with stimulation at 3 per sec. There is a moderate diminishing amplitude. Center, Immediately after exercise there is an increase in amplitude (post-tetanic facilitation). Bottom, 2 minutes later, the original defect is accentuated (post-tetanic exhaustion).

In the right-hand column are tracings of the patient with small cell carcinoma of the lung. The initial potentials are extremely small. After exercise the post-tetanic facilitation and then the exhaustion are profound compared to those of myasthenia gravis.

References

Goodgold J, Eberstein A: Electrodiagnosis of neuromuscular diseases. Williams & Wilkins, Baltimore, 1972.

Figures 1, 2, 3, 6 are from J Goodgold and A Eberstein, Electrodiagnosis of Neuromuscular Diseases, Williams & Wilkins, Baltimore, 1972.

Figures 4, 5, and 7 are from J Goodgold and A Eberstein, Clinical Neurophysiology in the Evaluation of "Weakness," Med Clinics of No Amer, 53:625-632, 1969.

A PILOT TRAINING PROGRAM IN LAPAROSCOPY IN A COMMUNITY HOSPITAL

MAHMOUD F EL-MINAWI MD
GERALD A GLOWACKI MD
SHAUKAT A ASHAI MD

From the Department of Obstetrics and Gynecology, Franklin Square Hospital, Baltimore Md 21237. Supported by Grant #4, Franklin Square Medical Foundation.

Reprint and information requests to Dr Glowacki, Director, Dept of Obstetrics and Gynecology, Franklin Square Hospital, 9000 Franklin Square Drive, Baltimore, Md 21237.

Abstract

A pilot Laparoscopy Training Program in a community hospital attracted most of the attending Gynecologists and can be used as a model for establishing other similar programs in community hospitals and developing countries. The establishment of a "staging area" was found to be extremely valuable with marked decrease in hospital expenses and efforts. The authors found that the use of the Touhy needle reduces the difficulties and complications of introducing the CO_2 and believe that this is the simplest needle to use in a laparoscopy training program. Tubal electrocoagulation and partial resection either by Palmer biopsy forceps or the scissors is sometimes accompanied by troublesome bleeding. The authors method, laparoscopic tubal electro-resection, is safe and eliminates the troublesome bleeding.

Introduction

Laparoscopy has proved to be a useful diagnostic and operative tool in modern Gynecology through the work of Kelling,¹ Jacobaeus,² Rud-dock,³ Palmer,⁴ and Semm.⁵ Almost every practicing Gynecologist can apply this diagnostic and therapeutic tool in the modern practice of Gynecology.

Our 300-bed community hospital began a training program in laparoscopy in July 1971 which may be used as a model for establishing other training programs in community hospitals and developing countries. It is the purpose of this communication to report on this training program and our experience with our first 220 laparoscopic procedures.

Material and Methods

The present laparoscopy training program started in July 1971 through the impetus of Johns Hopkins Hospital to afford our community with a rapid, safe, and effective means of

sterilization together with a means of safe and expeditious means of diagnosing the various maladies of the female pelvis. The program began in a two-step fashion: training the senior residents in Obstetrics and Gynecology in the use of the laparoscope, who secondarily assisted and guided the attending physicians in the use of the laparoscope. A series of lectures demonstrating the laparoscopic technique in conjunction with audiovisual facilities was used to orient the attending physicians, housestaff, and nursing personnel with the use of this new instrument.

Discussion of recent articles on laparoscopy was the main topic for several months in the departmental Journal Club. A bibliography on laparoscopy was prepared and made available to all interested persons for a more indepth study of the procedure. The senior residents were sent to national and local meetings on laparoscopy and afforded ample time to speak and discuss this topic with world-known Gynecologists experienced with laparoscopy. For the first months of the program the chief of service, in conjunction with the senior residents, assisted the attending physicians in the performance of the laparoscopic procedures they were performing. The technique was eagerly accepted by the housestaff as well as the attending physicians.

At the onset of the training program, the physicians were supervised in the performance of the laparoscopic technique until they felt comfortable in performing this as an independent procedure. At the onset of the program only four physicians were familiar with the technique; however, by the end of the first nine months of the program, 21 attending physicians had attained the skill whereby they performed the procedure independently.

Initially, the procedures were performed on an inpatient basis; however, by September 1971 a "staging area" had been developed to perform the procedures on an outpatient basis. The staging area consisted of two four-bed, fully equipped rooms in the Gynecology area. Patients, after in-

initially being seen in either the outpatient clinic or in the private physicians office where a history and physical examination of an abbreviated nature was completed, were scheduled for either a diagnostic or therapeutic laparoscopic procedure. Patients were instructed to arrive at the hospital at 7:30 AM being NPO from midnight and having had an enema at home prior to arrival.

After a brief interview in the admitting office, patients were taken to the laboratory whereupon a hematocrit and urinalysis were performed. They were then conducted to the staging area where intravenous fluids and preoperative medication were administered. They were subsequently conducted to the operating room where the laparoscopic procedure was performed. Patients were subsequently recovered in the general recovery room for approximately 45 minutes to one hour and then returned to the staging area where they could be further recovered, examined, and subsequently discharged.

This study comprises 220 such patients treated at this institution from July 1971 through April 1972. Their ages range from ten through 77 years and their parity between 0 and 10. The indication in the main was that of sterilization. A wide range of diagnostic laparoscopic procedures was performed as will be detailed later.

Table 1: Relation of the Duration of the Program to the Number of Trained Gynecologists

Month	Number of Trained Gynecologists
July 1971	4
August 1971	9
September 1971	10
October 1971	13
November 1971	13
December 1971	14
January 1972	15
February 1972	18
March 1972	21

Results

The laparoscopy training program attracted most of the attending Gynecologists; Table 1 illustrates the high degree of acceptance and the degree of success of the program. The trained physicians increased from four to 21 in nine months.

Material for the training program comprises 220 laparoscopic procedures including 179 laparoscopic tubal sterilizations and 41 diagnostic laparoscopies. Each group will be discussed separately.

Table 2: Ages of Patients Sterilized Via Laparoscopic Tubal Electrocoagulation and/or Electroresection

Age Group	Number of Patients
0-20	4
21-25	50
26-30	49
31-35	45
36-40	19
41 and above	12
Total	179

Table 3: Parity of Patients Sterilized by Laparoscopic Tubal Electrocoagulation and/or Electroresection

Parity	Patients
0	0
1	19
2	66
3	50
4	27
5	10
6	6
7 and above	1
TOTAL	179

Table 4: Previous Methods of Contraception Used by Patients Sterilized by Laparoscopic Tubal Electrocoagulation and/or Electroresection

Contraceptive Method	Number of Patients
"The Pill"	97
IUD	22
Foam	14
Condom	13
Diaphragm	1
None	32
TOTAL	179

Tubal Sterilization Group

The age and parity distribution is shown in Tables 2 and 3. The average age of the patients was 29 years with a range of 19-46 years. Eighty percent of the patients were between 21 and 35 years. The average parity was 2.8, with a range of 1-10. The trend was for patients to be sterilized by laparoscopy at a younger age and lower parity than in the previous laparoscopy series. Of the 179 patients, 160 patients were married, 16 separated or divorced, and three were single.

Previous contraception: The "pill" was the most common contraceptive used by our patients.

Table 4 shows the distribution of the different methods of contraception used by the Franklin Square Hospital patient population.

Indications: The main indication was voluntary sterilization. Patient counseling and sufficient patient maturity to understand the sequelae of the surgical sterilization was essential. Seventeen patients were sterilized on medical grounds, distributed as follows: rheumatic and congenital heart disease, five; genetic defects, three; failed postpartum tubal ligation, one; generalized sarcoidosis, one; hyperthyroidism, one; idiopathic thrombocytopenia, one; chronic pyelonephritis, one; hypertension, one; melanoma of the neck, one; and thalacemia minor, one.

Anesthesia and operative time: The average anesthesia time was 50 minutes with a range of 30 to 115 minutes. The average operative time was 35 minutes with a range of 15 to 85 minutes.

Difficulties: Laparoscopy was found technically more difficult in obese patients. The main difficulty encountered in the obese patients is the induction of a pneumoperitoneum. This was obviated by introducing the needle directly through the umbilicus in two patients. In general this procedure should be attempted in such patients only by an expert. Also, patients with previous abdominal scars required more care in the induction of a pneumoperitoneum and introduction of the laparoscopic trocar. No history of previous abdominal operations was noted in 150 patients. Twenty-nine patients had one or more previous abdominal incisions. The distribution of previous abdominal surgery was as follows: postpartum tubal ligation, two; cesarean section, seven; appendectomy, one; bilateral ovarian cystectomy, one; and cholecystectomy, two. One patient had three previous cesarean sections, but this did not complicate the procedure. There were six patients having more than one previous laparotomy.

Complications: Most of the complication difficulties have been due to faulty introduction of the Co₂ pneumoperitoneum. In six patients, the gas had collected in the retroperitoneal space. This was detected early and correct introduction of the Touhy needle was achieved. No case of subcutaneous emphysema occurred. The most serious complication encountered was intra-abdominal bleeding from the site of tubal resection and trauma to the bowel. Hemorrhage occurred after excision of the electrocoagulated tube using Palmer biopsy forceps in ten patients. In eight patients, the bleeding points were easily electrocoagulated through the laparoscope without sequelae. However, in two patients, an ex-

ploratory laparotomy was performed to control the bleeding.

Hazards of laparoscopic tubal electrocoagulation include burning of the peritoneum and/or viscera either through direct contact with the diathermy loop or by contiguous apposition. One of our patients was readmitted to Franklin Square four days after her discharge, following laparoscopic tubal ligation with the clinical diagnosis of abdominal distention and appendicitis. On laparotomy, a 1-cm-size perforation of the ileum, 25 cm above the ileo-caecal junction, was noted. Resection of 4 cms of the affected bowel and end-to-end anastomosis was performed. The postoperative course was uneventful. In another patient, the electrode touched the wall of the intestine. Although the burn was superficial, it was elected to open the patient and oversow the area. One case had a small suprapubic hematoma (2 × 2 cms) that was treated conservatively.

Associated operative procedures: Thirty operative procedures were performed with the laparoscopic tubal sterilization, distributed as follows: suction D & C, 12; diagnostic D & C, 12; removal of IUD, five; and excision of Gaertner's cyst, one.

Diagnostic laparoscopy: Laparoscopy was performed for diagnostic purposes in 41 patients. The indications for the laparoscopic procedures and these results are illustrated in Table 5. The parity ranged in the diagnostic group between 0 to 7. Twenty-four patients, more than one third of the diagnostic group, were between 20 and 25 years old. The oldest patient was a 74-year-old female with advanced ovarian carcinoma. Adequate follow-up time for our series has not

Table 5: Yield of Pelvic Endoscopy in the Diagnostic Laparoscopy Group

Cases	Pre-laparoscopy Diagnosis	Post-laparoscopy Diagnosis
16	Primary infertility	1) No pathology 6 2) Bilateral tubal block 3 3) Polycystic ovarian syndrome 3 4) Right ovarian cyst 3 5) Fibroid uterus (cornual) 1
14	Abdominal pain	1) Early pregnancy 1 2) No pathology 5 3) Polycystic ovaries 1 4) Tuboovarian adhesions 2 5) Bicornute uterus cone rudimentary horn 1 6) Endometriosis 4
4	Adnexal mass	1) Polycystic ovaries 1 2) No pathology 3) Pelvic adhesions 1
3	Pelvic endometriosis	1) Endometriosis 2 2) Bicornute uterus 1
1	Ectopic pregnancy	Corpus hemorrhagicum
1	Ovarian cancer	Ovarian cancer
2	Pelvic infection	1) Acute PID 1 2) Acute appendicitis 1

elapsed; the number of pregnancies, and thus the failure rate, cannot be determined. However, no pregnancies, to date, have occurred.

Average hospital stay: The average hospital stay before starting the "staging area" outpatient program was 24 hours. After establishing the staging area the average hospital stay was eight hours and the average postoperative hospital stay was four and one half hours. Three patients who were admitted as outpatients had to be admitted overnight for observation.

Discussion

The experience of our pilot laparoscopy training program proved that it can be used as a model for establishing other similar programs in community hospitals and developing countries. Within the first nine months of our program, all the attending Gynecologists and Residents were capable of performing the laparoscopy procedure independently.

The use of the staging area was found to be extremely valuable with a marked decrease in hospital expenses and efforts. It allows less burden on recovery room personnel who are left for the care of major procedures. It also gives the patient the security sensation of being in the hospital, well supervised, and the mental rest and assurance that she can go home to her family the same day.

The trend in this series was for the patient to be sterilized via laparoscopy at a younger age and lower parity than previously reported in the literature via laparotomy by Black, 1971,⁶ and Sacks and La Croix, 1962.⁷ This is undoubtedly a trend secondary to a more liberalized view on sterilization and population control.

Although the technique of laparoscopy is now almost standardized, there are certain steps, if utilized, that will facilitate the procedure and lower the incidence of complications. The use of Semm's vacuum cannula to manipulate the uterus and to inject indigo-carmin in infertility work-up, was found profitable. The use of two towel forceps to grasp the para-umbilical skin facilitates the introduction of the pneumoperitoneum needle and the trocar for the laparoscope. We found that the use of the Touhy needle reduced the difficulties of introducing the pneumoperitoneum. There is very slight resistance of the flow of the CO₂, producing a pressure reading of less than 15 mm Hg. We believe this is the simplest needle to use in a training program. The puncture site should be through the 2-cm infraumbilical transverse skin incision. This is an area in which the bowel is least likely to be adherent even after repeated lower abdominal operations.^{8,9}

Although there are several reported methods to ensure the intraperitoneal location of the needle, we found that connecting the cannula to the automatic pressure regulator is the simplest and most accurate method. Through this connection, we can observe the sudden drop of pressure in the manometer, ie, under 20 mm Hg, when the needle is in the peritoneal cavity. The presence of excessive pressure quickly indicates improper positioning of the needle. Introduction of the second puncture trocar and sleeve should be under direct vision to avoid hitting the peritoneal blood vessel that may lead to bleeding or hematoma formation. This last precaution also prevents injury of any hollow viscus or the uterine wall. This is most important in cases of combined suction D & C/Laparoscopy.

Previous abdominal operations or scars are not contraindications to laparoscopy. However, the trocar should be inserted in an unscarred area. Although bowel injury has been reported,^{3,10} during introduction of the trocar, we did not encounter any such complications. However, we have two instances of small-bowel injury following tubal electrocoagulation. The cause of the bowel injury was thermal burns. Two similar cases have been reported recently by other Gynecologic Laparoscopists.^{11,12}

To avoid burns of the bowel, the electric current should not be connected before grasping the tube and finding that the area to be fulgerated is free from adjacent structures. We also recommend that no attempt should be made to severe adhesions which are situated between intestinal loops because the heat created during electrocoagulation may injure the bowel. The burn may not appear immediately, but may manifest itself after a few days by abdominal distension and or abdominal pain. These were the presenting symptoms in our case. The point of coagulation and severance should not be in close proximity to a loop of bowel or hollow viscus.

Tubal electrocoagulation and partial resection by Palmer biopsy forceps was utilized in the early cases of our series. This was the procedure recommended by Palmer⁴ and Steptoe.¹³ However, we stopped using this technique because we encountered troublesome oozing due to incomplete electrocoagulation or tearing into the mesosalpex at the time of cutting the tube with the Palmer biopsy forceps. Electrocoagulation followed by cutting with scissors, as recommended by Peterson and Behrman, in 1971,¹² led to bleeding in some cases. Frangenheim¹⁴ performs the tubal ligation with an electrosurgical knife. Currently, we set our electrocoagulation unit on 35-40 cutting current. This method is the pro-

cedure of choice by Seigler.^{15,16} We did not encounter any patient who bled beyond the immediate postoperative period due to the lower voltage requirement of this technique. If we have to compare the scissors technique with the Palmer method, we believe that the former is the safer. Obtaining a sample of the tube for histological examination is meaningless since the amount of tissue negates accurate histologic diagnosis.

There is a growing need for combined therapeutic suction D & C and laparoscopic tubal sterilization. Some patients prefer this combined procedure because of the short period of hospitalization and low cost relative to hysterectomy. In such cases, there is added risk because the uterus is congested, vascular, and enlarged. Although the uterus diminishes in size after evacuation, it still occupies most of the pelvis and the tubes are displaced outwards and may well be lying over the brim of the pelvis. The tissues beneath the peritoneum here are in danger if the forceps are carelessly applied.¹⁷

Diagnostic laparoscopy has its place in everyday gynecologic practice. In infertility work-ups, the information obtained by laparoscopy surpasses that provided by any modality short of laparotomy. This is evident from Table 5 and from the reported experience in the literature.^{10,18,19} Hysterosalpingography gives no information regarding the tube beyond the site of obstruction. Tubal patency can be detected simply by means of instilling diluted indigocarmine dye. This procedure is especially useful in obese patients. In fact, the surgeon should be able, through laparoscopy, to reach a definitive evaluation of the operability of the tubal disorder with better operative results eventually. With proper selection and indications, the procedure can reveal information that will negate the possibility of laparotomy. We found this especially true in cases of endometriosis, pelvic inflammatory disease, and abdominal pain.

Although laparoscopy did not reveal any pathology, in some cases it assured the patient, as well as the physician, that the symptom complex of complaints was fully investigated.

Recently we started to perform more diagnostic laparoscopies in clinically diagnosed cases of acute pelvic inflammatory disease. Jacobson and Westrom²⁰ in Sweden used laparoscopy as a routine diagnostic aid in 905 cases, clinically diagnosed as acute pelvic inflammatory disease. They showed that the clinical diagnosis of pelvic inflammatory disease had limited accuracy and that the symptomatology often differs from what is generally accepted. They found that the pro-

cedure does not comprise any noticeable risk to the patients and did not aggravate the inflammatory process. Visual diagnosis contributed to improved prognosis of acute salpingitis due to early treatment.

Pelvic endometriosis presents a special challenge to the diagnostic accuracy of both the clinician and the gynecologic laparoscopist and requires special consideration. Diagnosis of ovarian endometriosis presents major difficulties. Pelvic endometriosis may mimic many pelvic pathological conditions in its presentation. Ovarian endometriosis can be diagnosed directly and without difficulty when the surface of a cystic or enlarged ovary has characteristic areas of scattered whitish tissue with dark blue or black blisters. Spillage of chocolate contents is a further valuable diagnostic aid. However, in some cases, diagnosis of ovarian endometriosis is difficult and can be diagnosed only indirectly when the ovary is fixed to the broad ligament and cannot be mobilized from its position. It is absolutely necessary to mobilize the ovaries in order to examine both surfaces of each ovary. Samuelson and Jovall²¹ found, in a total of 132 successfully performed laparoscopies for suspected endometriosis, the clinical diagnosis of endometriosis was correct in only 48% of their series.

No cardiac arrhythmias were recorded in our series. All patients were intubated and ventilated with positive pressure. No significant acid-base problems were encountered.

As sterilization procedures become more liberalized, the laparoscopic tubal electroresection is currently the easiest method of interval sterilization we can offer our patients. We feel that laparoscopy must be acknowledged as an acceptable and essential procedure in gynecologic practice and family planning projects in community hospitals and developing countries. We feel justified in believing that the results of our pilot laparoscopy training program should encourage establishment of other similar programs.

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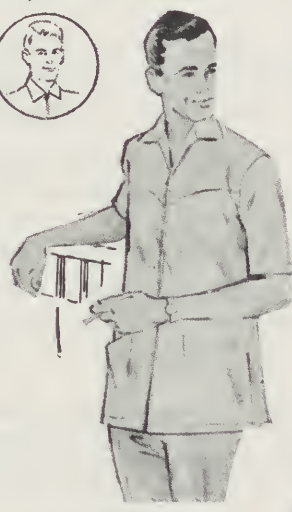
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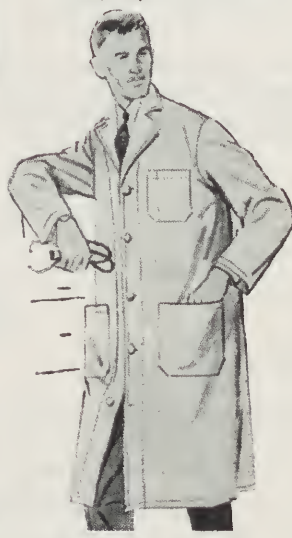
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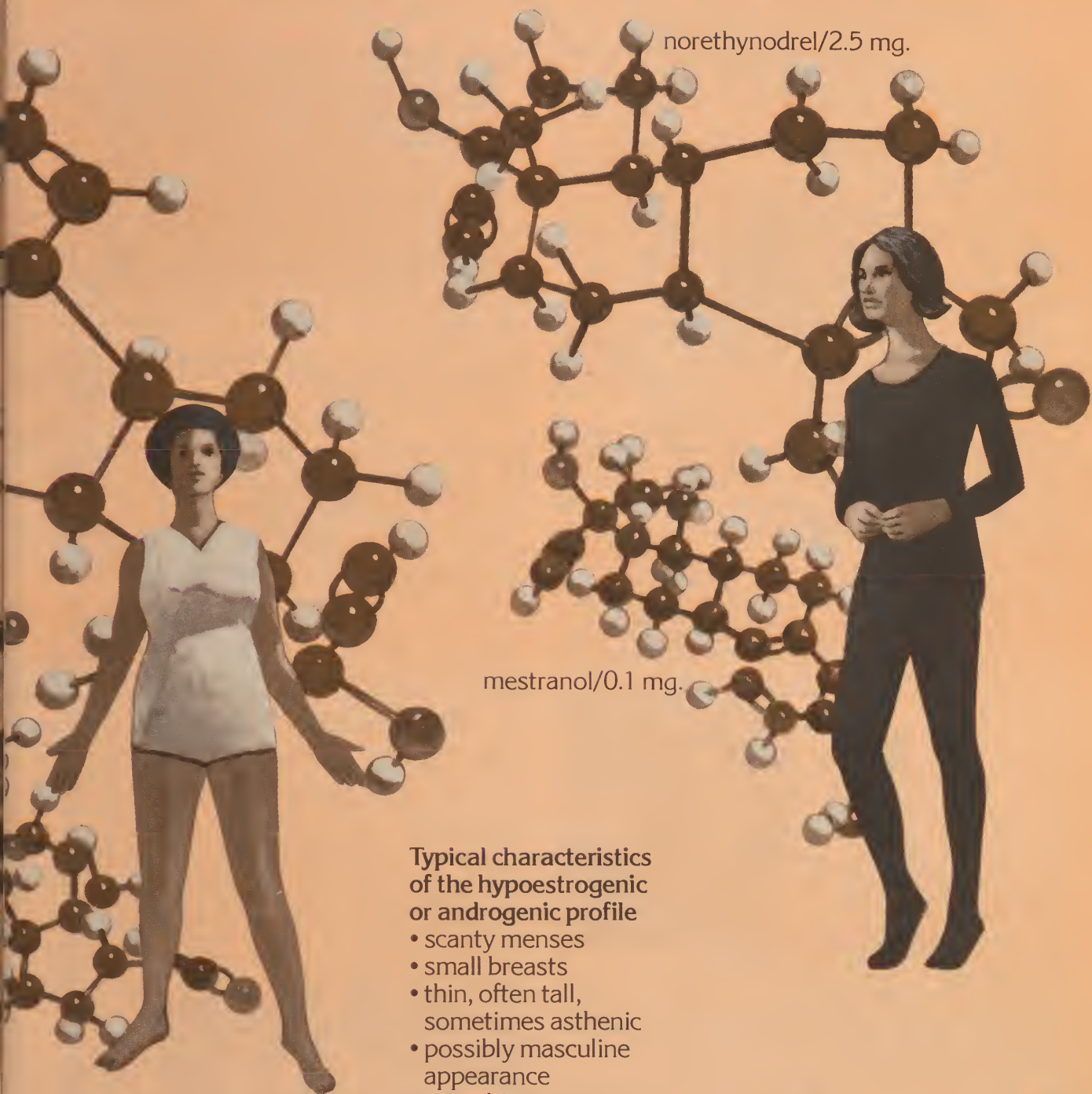
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Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain¹⁻³ leading to this conclusion, and one⁴ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible

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influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T³ uptake values; metyrapone test and pregnanediol determination.

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the heart page

His Bundle Recordings

LOUIS E GRENZER MD
Department of Medicine
University of Maryland Hospital
Baltimore Md 21201

The normal conducting tissue in the human heart includes the sinus node, the three intra-nodal tracts, the junctional tissue (AV node), the bundle of His, and the right and left bundle branches. The routine electrocardiogram records only the onset and duration of atrial and ventricular depolarization. One of the most important advances in electrocardiography in recent years has been the discovery that recordings can be made safely of His bundle depolarization in man.

Damato and Scherlag recorded His bundle depolarization in the intact dog in 1967 and then in man in 1969. The technique is simple and safe. A bipolar or multipolar catheter is inserted into the femoral vein percutaneously. This catheter is advanced into the right ventricle and then pulled back so that it is in the vicinity of the tricuspid valve. Recordings are made between the poles of the catheter. With experience, the catheter can be quickly positioned so that a bipolar rapid deflection appears between the P and QRS waves.

This wave represents depolarization of the bundle of His. On the electrocardiogram, atrial depolarization produces the P wave and ventricular depolarization produces the QRS complex. The interval between the P wave and atrial depolarization as recorded from the His bundle electrogram (P-A) is a measure of intra-atrial conduction. The A-H interval is a measure of the duration of AV nodal conduction. The H-V interval is a measure of conduction distal to the His bundle (see Fig 1).

Since this method was first described, there

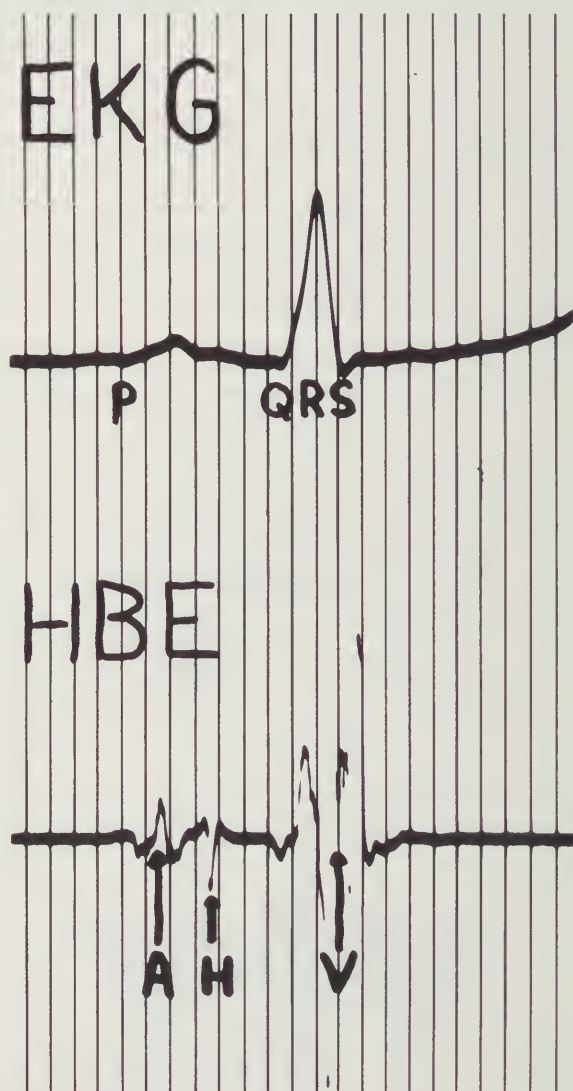


Fig 1:

P= start of P wave on EKG.

A= Atrial depolarization as recorded by bundle of His catheter.

H= His bundle depolarization.

V= beginning of QRS.

Delays can be within the atria (increased P-A), within the AV node (increased A-H), or below the bundle of His (increased H-V).

have appeared countless reports of His bundle recordings in man. The results of these studies have greatly enhanced knowledge of electrocardiography. It is of interest that, in most instances, His bundle recordings have supported rather than disproven the classical explanations of various arrhythmias. Knowledge gained from His bundle recordings is discussed here.

First Degree AV Block

In the presence of a narrow QRS complex, this usually indicates delay within the AV node (prolonged A-H interval). Delay in intraatrial conduction could also be responsible (prolonged P-A interval). However, if there is bundle-branch block, the delay may be either within the AV node or in the other bundle branch. It is also of interest that patients with bundle-branch block may have a prolonged H-V interval even when the P-R interval is normal. This is of importance because it indicates abnormal conduction in the nonblocked bundle branch, which means that the patient is at risk to develop complete heart block.

Second Degree AV Block

In Wenckebach phenomena, it is the A-H interval which progressively lengthens. The P wave which does not conduct to the ventricle is not followed by a His deflection. Thus, in Wenckebach phenomena, the block is within the AV node.

In Mobitz II block, there is no change in the A-H interval, the nonconducted P wave is followed by a His deflection, and the H-V interval is usually prolonged. Thus, Mobitz II block occurs below the bundle of His, that is bilateral, bundle-branch block.

Complete Heart Block

In most cases of complete heart block (18 out of 21), the QRS complex was not preceded by a His bundle deflection. Most of these cases (17 out of 18) had a wide QRS complex. In three of 21 cases, the QRS was preceded by a His bundle deflection, and two of these had a normal QRS complex. Thus, complete heart block most commonly occurs below the bundle of His (bilateral, bundle-branch block) and is usually associated with a broad QRS complex. In most cases of complete heart block with a narrow QRS, the block is within the AV nodal tissue. These observations confirm what was speculated by Mahaim back in 1931.

Acute Myocardial Infarction with Heart Block

His bundle recordings have confirmed that with inferior myocardial infarction, the block is usually within the AV node (QRS preceded by His deflection) while with anterior myo-

cardial infarction there is bilateral, bundle-branch block (QRS not preceded by His deflection).

Sinus Bradycardia

A high incidence of an abnormal H-V interval was found in patients with marked sinus bradycardia even when the P-R interval was normal. From a practical standpoint, it is important that the entire conducting system be evaluated in such a patient before instituting atrial pacing, which would be of no value if block subsequently developed at a lower level.

Wolff-Parkinson-White Syndrome

In Wolff-Parkinson-White syndrome (short P-R interval, wide QRS, and slurring of the initial portion of the QRS complex), it is thought that there are accessory pathways bypassing the AV node. It would, therefore, be expected that the His bundle deflection would occur after the beginning of the QRS. This has been confirmed with His bundle electrocardiograms. The effect of atrial pacing on the various intervals has been used to subclassify Wolff-Parkinson-White syndrome.

Understanding Complex Arrhythmias

His bundle electrograms may further clarify certain complex arrhythmias. In atrial fibrillation, for example, ectopic ventricular beats can be differentiated from aberrant ventricular conduction since the former are not preceded by an H deflection.

Premature atrial contractions which do not conduct to the ventricle may cause a pause on the electrocardiogram. Although this can, at times, raise the question of second-degree heart block, the premature P wave can be usually recognized on the routine electrocardiogram. However, a premature but nonconducted His bundle depolarization would produce no visible deflection on the routine electrocardiogram and could, therefore, exactly mimic second-degree heart block. A P wave would then not conduct to the ventricle because the His bundle would still be in the absolute refractory period. This possibility was recognized by Langendorf in 1947. Recently, there have been cases reported in which this mechanism was proven by His bundle electrograms.

Summary

Although there are relatively few instances in which His bundle electrograms influence the management of individual patients, this new procedure has greatly improved our knowledge of electrocardiography. However, in most cases, the His bundle recordings have merely confirmed rather than disproven classic descriptions of

electrocardiographic mechanisms. It is likely that in the future, use of this procedure will lead to further advances in our understanding and treatment of cardiac arrhythmias.

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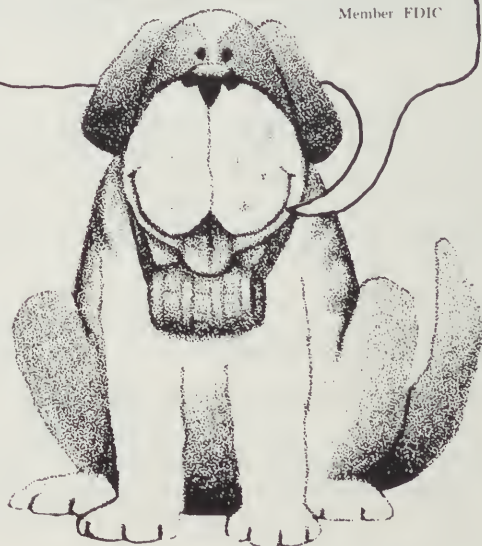
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Hopefully, we can demonstrate the searching possibilities of the machine at our Med-Chi annual meeting. So, those who have subjects they wish searched might consider bringing them to the annual meeting!

It is expected that later on two other medical libraries may join us in a consortium: Finney Memorial Medical Library, Union Memorial Hospital; and the Medical Staff Library, Sinai Hospital. In this event, connect time on the terminal network would be shared by the three participating libraries, the hospitals serving in their own communities and the Med-Chi Library covering the entire state. This consortium would be unique due to the combination of one medical society and two private hospitals being coordinated in such a service. Most of the regional medical library consortia at present are composed of either all-academic libraries or all-hospital libraries. Actually, few medical society libraries are functioning as AREA regional medical library facilities.

Notices regarding dates and schedule of operation as well as instructions for requesting searches will be mailed to all medical libraries in the state as well as individual users and paramedical organizations as soon as details are worked out.

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WEDNESDAY, APRIL 25, 1973

Concurrent Sessions

- 9:30 AM** MEETING OF THE HOUSE OF DELEGATES
- 12:30 PM** MMPAC LUNCHEON Meeting — Holiday Inn-Downtown
Guest speaker — **Russell B Roth** MD, President-elect of the American Medical Association
- 2:00 PM** PROBLEMS IN ISCHEMIC HEART DISEASE — Individual presentations moderated by **Richard S Ross** MD, Professor of Medicine and Clayton Professor of Cardiovascular Disease and Director of Cardiovascular Division, the Johns Hopkins University School of Medicine and Hospital
- EVOLVING CONCEPTS OF MYOCARDIAL ISCHEMIA: A BACKGROUND FOR THERAPY — **Bertram Pitt** MD, Associate Professor of Medicine, the Johns Hopkins University School of Medicine
- THE SYNDROME OF UNSTABLE ANGINA PECTORIS: A THERAPEUTIC CHALLENGE — **C Richard Conti** MD, Associate Professor of Medicine and Director of the Adult Cardiac Catheterization Laboratory, the Johns Hopkins University School of Medicine and Hospital
- MYOCARDIAL INFARCTION: EVALUATION OF THERAPY IN 1973 — **David T Kelly** MD and **Dean R Taylor** MD, Assistant Professors of Medicine, the Johns Hopkins University School of Medicine
- PANEL DISCUSSION by **Drs Ross, Pitt, Conti, Kelly, Taylor;** and **Leonard Scherlis** MD, Professor and Head of the Division of Cardiology, University of Maryland School of Medicine and Hospital
- 2:00 PM** DISEASES OF THE COLON
- INTRODUCTORY REMARKS — **J Parran Jarboe** MD, President, Maryland Chapter of the American College of Surgeons
- MODERATOR — **Jacob Charles Handelsman** MD, Associate Professor of Surgery, the Johns Hopkins University School of Medicine
- DIVERTICULITIS — **I Ridgeway Trimble Fund Lecture**—**Bentley P Colcock** MD, Senior Surgeon, Lahey Clinic, and Associate Professor of Clinical Surgery, Boston University School of Medicine
- UNUSUAL FEATURES OF CANCER OF THE LARGE BOWEL — **I Ridgeway Trimble Fund Lecture** — **Robert J Coffey** MD, Professor of Surgery, Georgetown University Medical School, and Director of Department of Surgery, Georgetown University Medical Center
- MEDICAL ASPECT OF DISEASES OF THE COLON — **Arthur E Cocco** MD, Instructor in Medicine, the Johns Hopkins University School of Medicine, and Chief of Gastroenterology at Church Home and St Joseph Hospitals in Baltimore
- BARIUM ENEMA: PITFALLS IN DIAGNOSIS — **John N Diaconis** MD, Assistant Professor of Radiology, University of Maryland School of Medicine

2:00 PM **DIFFICULT AND CURRENT PROBLEMS IN TREATMENT OF INFECTIOUS DISEASES**

MODERATOR — **Richard B Hornick** MD, Professor of Medicine and Head of Division of Infectious Diseases, University of Maryland School of Medicine and Hospital

TREATMENT OF GONORRHEAL INFECTIONS — **William B Greenough III** MD, Associate Professor of Medicine and Head of Division of Infectious Diseases, the Johns Hopkins University School of Medicine and Hospital

HOSPITAL ACQUIRED GRAM-NEGATIVE ROD INFECTIONS — **Herbert Dupont** MD, Associate Professor of Medicine, University of Maryland School of Medicine

UNDERSTANDING ANTIBIOTIC MECHANISMS OF ACTION — **Paul S Lietman** MD, Associate Professor of Medicine, Pediatrics, Pharmacology, and Experimental Therapeutics, the Johns Hopkins University School of Medicine

APPROPRIATE USE OF ANTIBIOTICS — **Frank M Calia** MD, Associate Professor of Medicine, University of Maryland School of Medicine; Head of Division of Infectious Diseases, Veterans Administration Hospital, Baltimore

3:45 PM **THE FAMILY PRACTICE APPROACH TO MANAGEMENT OF ILLNESS IN THE ACADEMIC MEDICAL SETTING** — Case presentations followed by discussion by the Staff of the Family Practice Program, University of Maryland School of Medicine —

J Roy Guyther MD, Associate Professor, Family Practice Program

C Earl Hill MD, Assistant Professor, Family Practice Program

Peter Hartmann MD, Jr Assistant Resident, Family Practice

William T Linthicum MD, Jr Assistant Resident, Family Practice

THURSDAY, APRIL 26, 1973

Concurrent Sessions

9:15 AM **RECOGNITION AND MANAGEMENT OF COMMON OCULAR PROBLEMS** — **Richard D Richards** MD, Professor and Head of Department of Ophthalmology, University of Maryland School of Medicine and Hospital

9:30 AM **WHY TREAT DIABETES** — **George M Boyer MD Lecture** — **Marjorie Peebles-Meyers** MD, Clinical Assistant Professor of Medicine, Wayne University School of Medicine

9:30 AM **CURRENT CONCEPTS IN THE TREATMENT OF CANCER**

MODERATOR — **Seymour Weiner** MD, Assistant Professor of Radiology, University of Maryland School of Medicine

SELECTION OF DEFINITIVE THERAPY IN CANCER OF HEAD AND NECK — **Grant E Ward MD Lecture** — **Robert G Chambers** MD, Assistant Professor of Surgery, the Johns Hopkins University School of Medicine

CURRENT TRENDS IN THE SURGICAL MANAGEMENT OF BREAST CANCER — **R Robinson Baker** MD, Associate Professor of Surgery, and Surgeon-in-Charge of Breast Clinic, the Johns Hopkins University School of Medicine and Hospital

THE ROLE OF RADIOTHERAPY IN PATIENTS WITH PROSTATIC CANCER — **Tapan Hazra** MD, Acting Director, Division of Radiotherapy, the Johns Hopkins Hospital

CURRENT TRENDS IN THE SURGICAL MANAGEMENT OF BRONCHOGENIC CARCINOMA — **Joseph S McLaughlin** MD, Professor and Head, Division of Thoracic and Cardiovascular Surgery, University of Maryland School of Medicine and Hospital

CANCER OF THE COLON — **Harold E Ramsey** MD, Chief of Tumor Surgery and Deputy Chief of Surgery, USPHS Hospital, Baltimore

- 10:30 AM** THE INEVITABLE REVIEW OF PHYSICIAN PERFORMANCE: HOW AND BY WHOM? — **Alan R Nelson** MD, President, Utah Professional Review Organization
- 10:45 AM** MODERN TRENDS IN GERIATRIC MEDICINE — **Jesse C Coggins Fund Lecture** — **W Ferguson Anderson** MD, David Cargill Professor of Geriatric Medicine, University of Glasgow, Scotland
- 11:15 AM** SEXUALITY AND THE PRACTICE OF MEDICINE — **Hundley Memorial Lecture in Gynecology** — **Mary S Calderone** MD, Executive Director, Sex Information and Education Council of the US (SIECUS)
- 2:30 PM** THE PROBLEMS OF POLYARTHRITIS —
Mary Betty Stevens MD, Associate Professor of Medicine, the Johns Hopkins University School of Medicine
Werner F Barth MD, Chairman, Section of Rheumatology, Washington Hospital Center; Associate Professor of Medicine, George Washington University
Harry F Klinefelter MD, Associate Professor of Medicine, the Johns Hopkins University School of Medicine
Thomas M Zizic MD, Instructor in Medicine, the Johns Hopkins University School of Medicine
Jack W Bowerman MD, Assistant Professor of Radiology, the Johns Hopkins University School of Medicine
Gaylord L Clark MD, Assistant Professor of Orthopedic Surgery, the Johns Hopkins University School of Medicine
- 2:30 PM** STAGING AND TREATMENT OF LYMPHOMAS OF THE SKIN — **William Royal Stokes Memorial Fund Lecture** — **Richard K Winkelmann** MD, Chairman, Department of Dermatology, Mayo Clinic, Rochester, Minn
- 2:30 PM** POST-SURGICAL RESPIRATORY INSUFFICIENCY — **T Crawford McAslan** MD, Professor and Head, Respiratory Division, Department of Anesthesiology and Center for the Study of Trauma, University of Maryland School of Medicine and Hospital
- 3:45 PM** NEWER CONCEPTS IN PLASTIC SURGERY — **F X Paletta** MD, Director of Plastic Surgery, St Louis University School of Medicine
- 4:00 PM** PROBLEMS OF SMELL IN MEDICAL PRACTICE — **Robert I Henkin** MD, Chief, Section on Neuroendocrinology, National Heart and Lung Institute, NIH

FRIDAY, APRIL 27, 1973

Concurrent Sessions

- 9:30 AM** THE CHRONIC RENAL FAILURE PATIENT: DIALYSIS AND TRANSPLANTATION
 CONSERVATIVE MANAGEMENT AND PATIENT SELECTION — **W Gordon Walker** MD, Professor of Medicine, the Johns Hopkins University School of Medicine
 HEMODIALYSIS: FIVE YEARS EXPERIENCE WITH A CHRONIC PROGRAM — **C Robert Cooke** MD, Associate Professor of Medicine, the Johns Hopkins University School of Medicine
 EXPERIENCE WITH A CADAVER-BASED TRANSPLANTATION PROGRAM — **Ronald T Rolley** MD, Assistant Professor of Surgery, the Johns Hopkins University School of Medicine
 ORGAN PROCUREMENT — **John H Sadler** MD, Associate Professor of Medicine, University of Maryland School of Medicine

INFECTIONS IN IMMUNOSUPPRESSED PATIENTS — **Patricia C Charache** MD, Assistant Professor of Medicine, the Johns Hopkins University School of Medicine

THE CLINICAL SIGNIFICANCE OF IDIOPATHIC PROTEINURIA — **Albert E Goldstein Memorial Lecture** — **Roscoe R Robinson** MD, Professor of Medicine and Director of the Renal Division, Duke University School of Medicine

9:30 AM

NEWBORN EMERGENCIES

NEWBORN SURGICAL EMERGENCIES — **J M T Finney Fund Lecture** — **Jens G Rosenkrantz** MD, Chief of Pediatric Surgery, Children's Hospital, Los Angeles

RESPIRATORY DISTRESS SYNDROME: CURRENT STATUS — **Ronald L Gutberlet** MD, Assistant Professor of Pediatrics and Director of Nurseries, University of Maryland School of Medicine and Hospital

CONGENITAL HEART DISEASE: A NEONATAL EMERGENCY — **Herman M Risemberg** MD, Chief, Division of Neonatology, Baltimore City Hospitals; Assistant Professor of Pediatrics, the Johns Hopkins University School of Medicine

9:30 AM

THE THERAPEUTICS OF CONGESTIVE HEART FAILURE — Discussion by members of the staff of the University of Maryland School of Pharmacy — **William J Kinnard Jr** PhD, Dean

Robert A Kerr PharmD, Assistant Professor of Pharmacy

Anthony S Manoguerra PharmD, Instructor in Pharmacy

John B Young PharmD, Assistant Professor of Pharmacy

10:45 AM

EVALUATION AND MANAGEMENT OF LUMBAR DISCOGENIC DISEASE — **Harvey Grant Beck Memorial Lecture** — **Rene Cailliet** MD, Professor and Chairman, Department of Physical Medicine and Rehabilitation, University of Southern California School of Medicine

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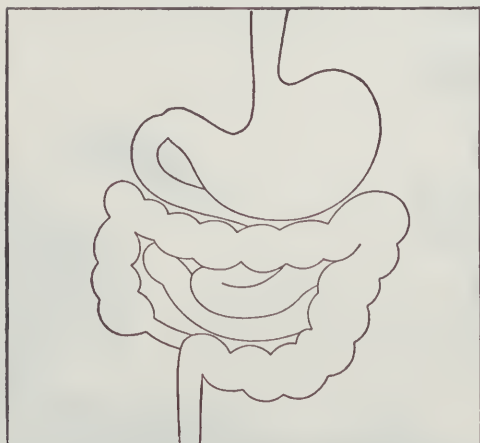
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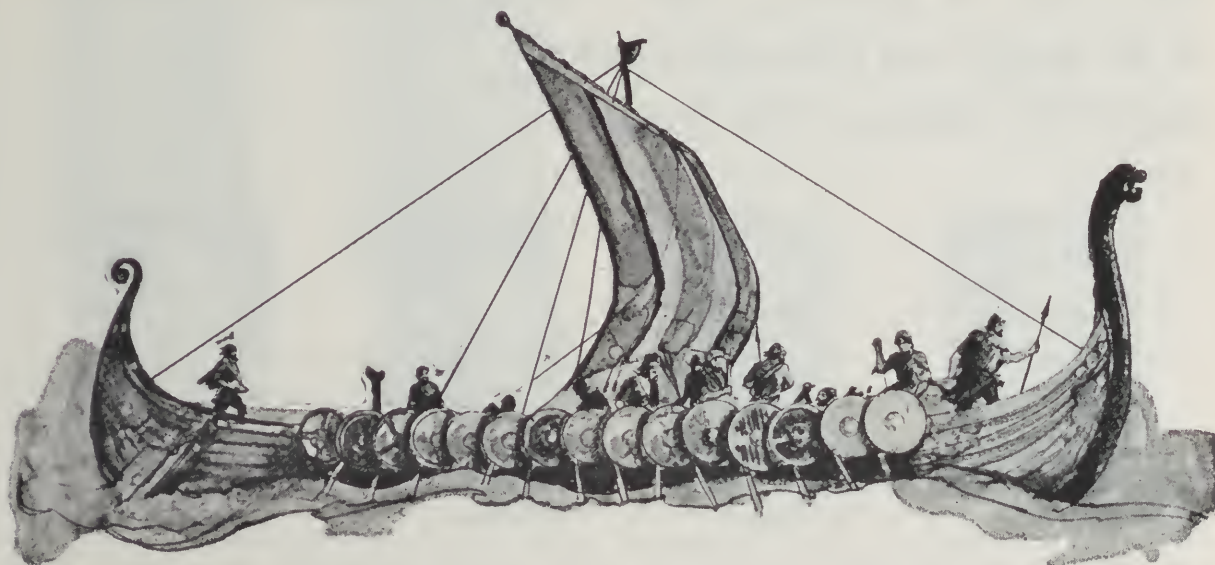
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More About the Speakers at the 175th Annual Meeting of the Medical and Chirurgical Faculty April 25-27, Baltimore Civic Center



Dr Coffey



Dr Anderson



Dr Henkin



Dr Winkelmann

Dr Coffey

An **I Ridgeway Trimble Lecture** will be presented during the Annual Meeting on Wednesday afternoon, April 25, by **Robert J Coffey MD, PhD, DSc, FACS**. He will discuss **UNUSUAL FEATURES OF CANCER OF THE LARGE BOWEL**, as a part of a session on Diseases of the Colon. Dr Coffey is Professor of Surgery, Georgetown University Medical School. Dr Coffey received his MD at Georgetown University Medical School, and an MS in medicine and a PhD in Surgery at the University of Minnesota in Minneapolis. He is currently a consultant in surgery at the US Naval Hospital in Bethesda, the Andrews Air Force Base Hospital, the Mt Alto Veterans Hospital, and the Walter Reed Army Hospital.

Among the many offices Dr Coffey has held are President of the Southeastern Surgical Congress, President of the Southern Surgical Association, President of the Medical Society of the District of Columbia, and Chairman of the Conference Committee on Graduate Education in Surgery. He is a Governor of the American College of Surgeons, President-elect of the Mayo Alumni Association, and Editor-in-Chief of *Surgery Digest*. Dr Coffey is also the author of approximately 100 scientific articles and a contributor to four textbooks on surgery.

Dr Anderson

MODERN TRENDS IN GERIATRIC MEDICINE will be the title of the **Jesse C Coggins Lecture** to be given by **W Ferguson Anderson OBE, MD, FRCP**, of the University of Glasgow.

Scotland. Dr Anderson holds, or has held, the following appointments: Adviser in Diseases of Old Age and Chronic Sickness, Western Regional Hospital Board, Scotland; Physician in Geriatric Medicine, Stobhill General Hospital, Glasgow; Honorary Clinical Lecturer, University of Glasgow; David Cargill Chair of Geriatric Medicine, University of Glasgow; Visiting Professor, University of Manitoba, Canada; Lecture Tour, Denmark; Temporary Consultantship, Israel; Traveling Professorship, New Zealand and Australia; Visiting Professor, University of Arkansas; Honorary Chairman, European Clinical Section, International Association of Gerontology; Senior Lecturer in Medicine, Welsh National School of Medicine; and Honorary Consultant Physician, Cardiff Royal Infirmary. Dr Anderson is the author of *Practical Management of the Elderly* (1971), and many articles, especially on preventive aspects of geriatric medicine.

Dr Anderson will give this talk on Thursday morning, April 26. He will also moderate a table at the annual Lunch and Learn Session that same day at the Holiday Inn-Downtown. At that time his subject will be **DRUG THERAPY IN THE AGED**.

Dr Henkin

PROBLEMS OF SMELL IN MEDICAL PRACTICE is the title of a paper to be presented by **Robert I Henkin MD, PhD**, Chief of the Section on Neuroendocrinology of the National Heart and Lung Institute, NIH, on Thursday afternoon, April 26. Dr Henkin received his AB, MA, PhD, and MD degrees from the Univer-



Dr Paletta



Dr Nelson

Dr Paletta

F X Paletta MD, Director of Plastic Surgery at the St Louis University School of Medicine, will speak on **NEWER CONCEPTS IN PLASTIC SURGERY** on **Thursday, April 26**. He is a graduate of Marquette University School of Medicine and received further medical training at the St Francis Hospital in Pittsburgh, the University of Virginia Hospital in Charlottesville, Barnard Skin and Cancer Hospital in St Louis, and the Presbyterian Hospital in New York City. His military training included serving on the Maxillofacial Team in the European Theatre for two years.

Dr Paletta, who is in private practice, includes among his teaching appointments that of Professor of Clinical Surgery at St Louis University School of Medicine, Professor of Clinical Surgery at St Louis University School of Dentistry, Chairman of the Cleft Palate Clinic at the Cardinal Glennon Memorial Hospital, and is on the Consulting Plastic Surgical Service at the Veteran's Hospital in St. Louis. He is a member of many scientific societies and the author of many publications.

Dr Nelson

THE INEVITABLE REVIEW OF PHYSICIAN PERFORMANCE: HOW AND BY WHOM? will be discussed by **Alan R Nelson MD**, President of the Utah Professional Review Organization on **Thursday, April 26**. This subject has been underscored by the passage of PL 92-603, which mandates a degree of national standards for medical care. Physicians are entering into a new medical scientific discipline studying processes by which their services are delivered. The review system must be coupled to an education program to correct deficiencies identified by review.

Dr Nelson is a practicing internist in Salt Lake City with a subspecialty interest in endocrinology. Besides serving as President of the Utah Professional Review Organization, he is a Clinical Assistant Professor of Medicine, a consultant to the National Center for Health Services Research and Development, alternate delegate to the American Medical Association, a member of the Peer Review Committee of the American Society of Internal Medicine and of the Advisory Committee to the President-elect of the ASIM. He also serves as President-elect of the Utah Society of Internal Medicine, and was voted Utah's Young Internist of the Year for 1972.

sity of California in Los Angeles. He served an internship in medicine at the University of California and a residency in medicine at the Jackson Memorial Hospital, University of Miami. Dr Henkin has been a research associate, Laboratory of Clinical Science, National Institute of Mental Health; a senior investigator, Clinical Endocrinology Branch of the National Heart and Lung Institute; and a consultant, Gynecologic Endocrinology Clinic, Lenox Hill Hospital in New York City. Since 1963 he has been senior surgeon USPHS, Experimental Therapeutics Branch of the National Heart Institute. Dr Henkin is a member of many professional organizations, and has received numerous honors and awards. His PhD is in music and since 1952 he has done freelance composition of music for motion pictures, radio, and theatrical productions in Los Angeles and Washington DC.

Dr Winkelmann

Richard K Winkelmann MD will give the **William Royal Stokes Memorial Lecture on STAGING & TREATMENT OF LYMPHOMAS OF THE SKIN** on Thursday afternoon, April 26. Dr Winkelmann is Chairman of the Department of Dermatology at the Mayo Clinic in Rochester, Minn. He received his MD from Marquette School of Medicine and served an internship at the St Louis City Hospital. His medical education and training further includes a postdoctoral fellow, Atomic Energy Commission; a fellow in dermatology, Mayo Foundation; doctor of philosophy in dermatology, University of Minnesota Graduate School; and many other similar programs. Dr Winkelmann has been, and still is, a consultant in the Section of Dermatology, Mayo Clinic; Associate Professor of Anatomy and Professor of Dermatology at the Mayo Foundation Faculty, Graduate School, University of Minnesota. He is a member of numerous national and foreign medical societies, and has served visiting professorships at such medical schools as Johns Hopkins, Columbia, Harvard, Duke, St Marys, and St Bartholomew's in London.



Dr Cailliet



Dr Peebles-Meyers

Dr Cailliet

EVALUATION AND MANAGEMENT OF LUMBAR DISCOGENIC DISEASE will be the title of the Harvey Grant Beck Memorial Lecture to be given by **Rene Cailliet MD** on **Friday, April 27**. Dr Cailliet, Professor and Chairman of the Department of Physical Medicine and Rehabilitation at the University of Southern California School of Medicine, received his BA and MB degrees at Villanova College and his MD at the University of Southern California.

Dr Cailliet was certified in Physical Medicine and Rehabilitation in 1953 and became a Fellow of the American Academy of Physical Medicine and Rehabilitation in 1963. He has served as Medical Director of the Kabat-Kaiser Institute in Washington DC, Chief of the Department of PM&R at the Kaiser Foundation Hospitals, Independent Medical Examiner for the State of California, Committee on Continuing Medical Education of the California Medical Association, Consultant to the Tripler General Hospital in Hawaii and the Letterman General Hospital in San Francisco, and in many other capacities. Dr Cailliet is the author of numerous publications and has lectured throughout the world.

Dr Peebles-Meyers

Marjorie Peebles-Meyers MD, an internist in private practice in Detroit and adjunct assistant professor in the Department of Medicine at Wayne State University, will give the **George M Boyer MD Lecture** during the Faculty's Annual Meeting on **Thursday morning, April 26**, at the Baltimore Civic Center. Her discussion will be on **WHY TREAT DIABETES**.

Dr Peebles-Meyers received her BA at Hunter College, her MA at Columbia University, attended Howard University Medical School, and received her MD from Wayne State Univ School of Medicine. She served an internship and residency at the Detroit General Hospital and is certified by the American Board of Internal Medicine.

A delegate to the Michigan State Medical Society from Wayne County, she is also an alternate delegate to the American Medical Association from the Michigan State Medical Society. She is a member, on the board of trustees, and on advisory boards of numerous national and state organizations which include civic as well as medically oriented groups. Among her many honors, Dr Peebles-Myers was voted the outstanding physician of 1968 by the Michigan State Medical Society and the same year was one of the Top Ten Women Who Work by the Detroit Chamber of Commerce.

Dr Roth

At the Maryland Medical Political Action Committee Luncheon (MMPAC) on **April 25**, at the Holiday Inn-Downtown, the guest speaker will be **Russell B Roth, MD**, President-elect of the American Medical Association. The title of his talk, **FOR CRISIS SAKE, WHAT'S NEXT!**, will deal with the diverse socioeconomic and political problems that have been thrust upon the medical profession and with steps that the AMA is taking to overcome them.

When the AMA's House of Delegates declared by acclamation that Russell B Roth MD would be the Association's new President-elect, the physician members provided the pinnacle in the long and distinguished career of the 59-year-old native Erie Pa urologist. His election by acclamation came as little surprise. Since 1969, Dr Roth had distinguished himself as the Speaker of the AMA House of Delegates. He had served as Vice-Speaker of the House from 1966.

He received his bachelor degree from Yale University and his MD from Johns Hopkins University.

Even with the heavy demands upon him as AMA President-elect, Dr Roth will continue his practice as an attending Urologist at St Vincent's Hospital and as a consulting urologist for the VA Hospital, both in Erie.

Dr Roth has also distinguished himself as an author and lecturer on urological subjects. He is a member of the American Urological Association and the American Association of Clinical Urologists, and a Fellow of the American College of Surgeons.

Dr Roth's service to the AMA has included participation in several committees and the chairmanship of the Council on Medical Service. In his home state, Dr Roth has served as the chairman of the Pennsylvania Medical Society's board of trustees, a member of its Commission on Cancer, chairman of its Council on Medical



Dr Roth



Dr Robinson

Service, and speaker of its House of Delegates. He also served the Erie County Medical Society as President (1955), Vice President, Secretary, and Censor. Dr Roth has served 15 years as a member of the advisory health board of the Commonwealth of Pennsylvania.

In addition to his service to organized medicine, Dr Roth served as a member of the Surgeon General's Advisory Committee on the US National Health Survey (1961-64), and as a member of the Dependents Medical Care Advisory Committee.

He is currently a member of the National Advisory Council for Regional Medical Problems in HEW and has been a member of the Special Medical Advisory Group for the Veterans Administration.

A veteran of World War II, Dr Roth has been quite active in civic affairs. He is a past member of the board of governors of the Erie Club; a past director of the Erie Yacht Club; a 32nd degree Mason, Shriner, and Jester; a Rotarian; and a member of the Presbyterian Church of Erie.

An active sportsman, his hobbies include hunting and fishing. With the current demands upon his time, he treasures spending as much time as possible with his wife, Jeanne, aboard their houseboat on Lake Erie.

At the annual luncheon of the Woman's Auxiliary to the Med-Chi, Dr Roth will speak on PILLS, PATIENTS, AND POLITICS. This luncheon is being held on Thursday, April 26 at the Holiday Inn — Downtown.

Dr Robinson

CLINICAL SIGNIFICANCE OF IDIOPATHIC PROTEINURIA is the title of the Albert E Goldstein Memorial Lecture to be given by Roscoe R Robinson MD on Friday morning, April 27, at the Baltimore Civic Center. Dr Robinson will include in his discussion the dif-

fering patterns of "types" of qualitative proteinuria, ie, postural, orthostatic, transient, intermittent, isolated, cyclic, constant, persistent, etc.

Dr Robinson received his MD from the University of Oklahoma School of Medicine, and served an internship and residencies at the Duke University Medical Center. As a Captain in the USAF (MC) he was Chief of the Renal Unit at the USAF Aerospace Medical Center, Lakeland AFB. Dr Robinson is a Diplomate of both the National Board of Medical Examiners and the American Board of Internal Medicine. He has held office and served on committees and editorial boards of numerous state and national organizations. He is also the author or coauthor of almost 100 publications.

At present, Dr Robinson is Professor of Medicine and Director of the Division of Nephrology at Duke University Medical Center; Senior Investigator of the North Carolina Heart Association; attending physician at the VA Hospital in Durham; Consultant in Nephrology at the VA Hospital in Fayetteville, the US Naval Hospital in Portsmouth Va, and the Research Triangle Institute in North Carolina; and is National Consultant in Medicine (nephrology) to the Surgeon General of the US Air force.

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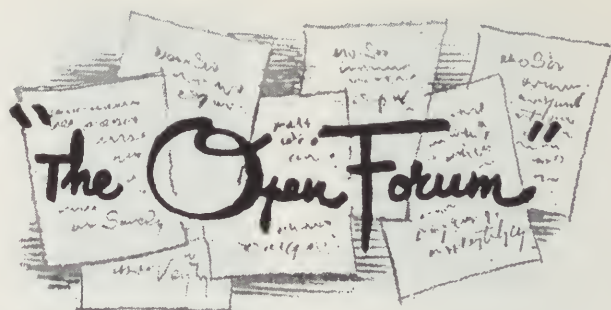
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Flint Laboratories
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Hidden Brook Treatment Center for Alcoholism
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In lieu of an exhibit, contributions have been received
from Geigy Pharmaceuticals and Hynson, Westcott &
Dunning Inc



An Appeal for Help

Editor's Note: The self-explanatory article that follows is reprinted from an HEW Newsletter in hope that some reader of the Journal may be able to help Ed.

Anyone knowing a physician, hospital, medical clinic, or other institution that has successfully treated a patient with progressive bulbar palsy is urgently requested to write Edward J Stevens, Editor, HEW Newsletter, Room 4233, DHEW North, Washington DC 20201, phone (202) 963-4013.

It is a motor neuron disease of unknown etiology, a form of amyotrophic lateral sclerosis. The biomedical scientists at NIH diagnosed Ed's condition as progressive bulbar palsy in September 1970 but the neurosurgeon in charge of his case lost interest once the diagnosis was made. He has no guidance from NIH.

Time is running out since death usually occurs within three or four years after the onset of symptoms. Since the HEW Newsletter is read by 60,000 persons including medical men and administrators of hospitals and clinics throughout the country, Ed thought an appeal like this may give him a clue to a cure or treatment.

Med Student Aid

The AMA is serving as a clearinghouse for students seeking financial assistance to help them train for careers in medicine and allied fields. The two-phase public service program, known as FIND (Financial Information National Directory), is being conducted with the full cooperation of health professions organizations, governmental agencies, schools, and private organizations.

More than 1000 sources of financial aid are listed in the directory, FIND '72-Health Careers. Copies, \$2.95 each, are available from Order Dept, AMA. The program also includes a computer search service that matches a student's needs and qualifications with current sources of funds. Write FIND, AMA, for information.

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Physician / Patient Relations Committee

The Physician/Patient Relations Committee of the Faculty met on Thursday, Jan 25, 1973 and adopted the following amended report:

Report of Subcommittee on Advertising Guidelines—Group Practices

Recognizing there are instances when it is important for residents of a community to be aware of newly formed medical programs or services available to them, the Mediation Committee again emphasizes previous rulings it has made in this regard.

On Nov 19, 1970 the Council of the Faculty adopted the following policy:

"The Faculty supports the concept that medical care can be delivered through various mechanisms, including closed panel programs; provided individual physicians render such health care on an equitable basis and further provided that the patient has the right to choose the mechanism through which he will receive such health care."

On Oct 5, 1971 the Mediation Committee (now Physician/Patient Relations Committee) adopted the following policy and recommended that the Board of Medical Examiners legalize it by regulation:

"1) Valid descriptions of programs, their benefits, costs, etc may be publicized but 'puffing,' indicating, or attempting to indicate that the program provides superior quality medical care or services is prohibited.

"2) Payment for any advertising, circulars, or brochures, however described, must be by the third-party carrier and not the plan or program itself.

"3) Use of the name of any school, hospital, university, clinic, or other facility other than that of the plan itself is prohibited.

"4) Use of pictures, names, biographical sketches, or other references to individual

physicians, professional associations, or corporations is prohibited.

"Press releases must be in conformity with the above criteria, except that a physician may act as a spokesman in a medical capacity on medical matters only. In doing so, however, such action should be in accord with policy statements previously adopted in connection with public announcements on April 27, 1970. Such spokesman, in addition, should not engage in direct or indirect 'puffing,' or indicating or attempting to indicate that superior treatment or services are provided.

"Where necessary, radio and television interviews, public speaking engagements, public debates, panel shows, 'talk' shows, etc are permissible, subject to the same restrictions outlined in the preceding paragraph."

The Subcommittee also recommends that:

1) Component societies be urged to make available on a regular basis to the community a listing of physicians in that area, with name, address, and specialty. This can be done by a telephone referral service or use of facilities such as Welcome Wagon hostesses, etc.

2) All physicians be notified when they are licensed and subsequently when triennial re-registration occurs of the existence of such prescriptions. In this manner, a claim that the physician was unaware of such a requirement would be avoided.

3) The Board of Medical Examiners and Commission on Medical Discipline be urged to amend regulations on advertising to include the above policies of the Faculty; as well as a provision that physicians who benefit directly or indirectly from advertising not in conformance with the above be considered to be in violation of the statutes in this regard.

Approved by
Physician/Patient Relations Committee
1/25/73

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Component Societies Elect Officers

In addition to Baltimore City (reported in the March Journal), officers selected for the current year by the various component societies are listed here for your ready information. All are MDs.

Alleghany County

President: Walter F Oster
President-elect: to be filled
Secretary-Treasurer: Jack W Harvey

Anne Arundel County

President: Charles R MacDonald
Vice President: Theodore G Osius Jr
Secretary: Clayton Norton
Treasurer: Antonio M Rivera

Baltimore County

President: Baltasar B Velez
Vice President: J Donald Drinkard
Secretary: Eugene J Riley
Treasurer: Harry J Connolly

Calvert County

President: Roberto DeVillarreal
President-elect: Thomas F Lusby II
Secretary: Page C Jett

Caroline County

President: Henry R Trapnell
Vice President: Harold B Plummer

Carroll County

President: Daniel I Welliver
President-elect: to be selected
Secretary: Reynaldo P Madrinan
Treasurer: John E Steers

Cecil County

President: Barry R Barnhart
Vice President: Zin Uoo Parks
Secretary-Treasurer: James L Johnson

Charles County

President: Ignatio T Garcia
Vice President: Henry L Burke III
Secretary-Treasurer: J Parran Jarboe

Dorchester County

President: Reinaldo A Faget
Vice President: Peter W Rieckert
Secretary-Treasurer: Manuel De La Rocha

Frederick County

President: Robert R R Roberts
President-elect: J Fred Baker
Secretary: Joseph A Matan
Treasurer: Timothy F Hickey Jr

Garrett County

President: Joseph Alvarez
Vice President: Terrance J Thomas
Secretary-Treasurer: Herbert H Leighton

Harford County

President: Henry H Kwal
Vice President: Gunther D Hirsch
Secretary: Marco Clayton
Treasurer: Edward J Simon

Howard County

President: Lewis B Newburg
Vice President: B Martin Middleton
Secretary: A Carl Segal
Treasurer: Vernon R Croft

Kent County

President: Alexander C Dick
Vice President: Geza Koralewski
Secretary-Treasurer: John S Green III

Montgomery County

President: Herman C Maganzini
President-elect: to be elected
Vice President: Francis C Mayle Jr
Secretary: Richard M Schisgall
Treasurer: John B Umhau Jr

Prince George's County

President: William B Gunther
President-elect: John T Lynn
Secretary: Barry Rosenberg
Treasurer: George S Malouf

Queen Anne's County

President: John R Smith Jr
Secretary-Treasurer: Ralph E Libby

St Mary's County

President: Eugene Guazzo
Vice President: Juanito C Roa
Secretary-Treasurer: Juana S Cockburn

Somerset County

President: James A Sterling
Secretary-Treasurer: C G Rawley

Talbot County

President: James P Thompson
1st Vice President: John H Hawkinson II
2nd Vice President: John I F Knud-Hansen
Secretary-Treasurer: Louis S Welty

Washington County

President: Edson B Moody
President-elect: Charles C Spencer
Vice President: Francisco G Japzon
Secretary: Max E Byrkit
Treasurer: Frank E Brumback

Wicomico County

President: William R Campbell
President-elect: Aubrey C Smoot
Vice President: Aubrey C Smoot
Secretary-Treasurer: Robert L Dickey

Worcester County

President: Frank E Gantz Jr
Vice President: Norman E Sartorius
Secretary: Jesus G Santiano

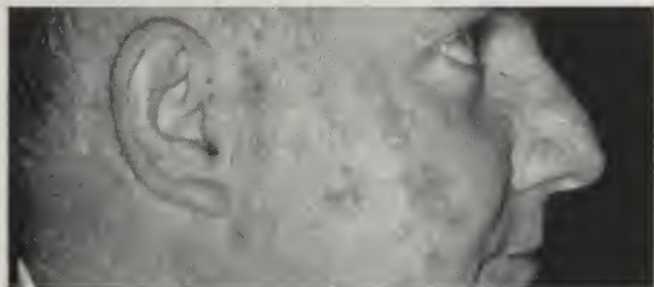
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**may be more important than
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The lesions on his face may be solar/actinic — so-called “senile” keratoses...and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics: the typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent, and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.



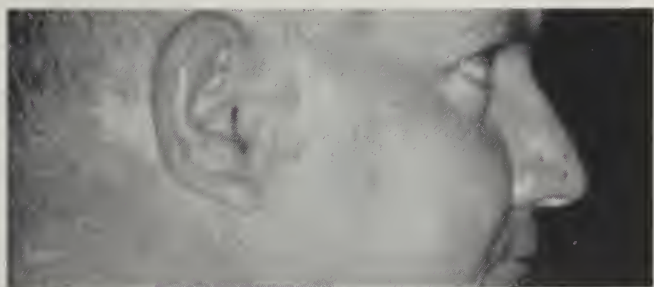
Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electro-surgical procedures.

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Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local — pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported — insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

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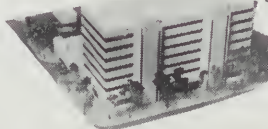
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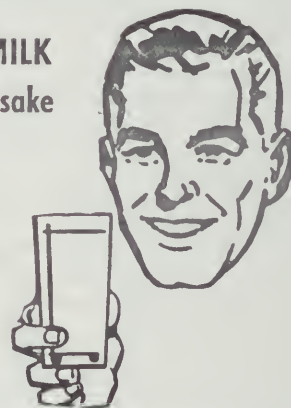
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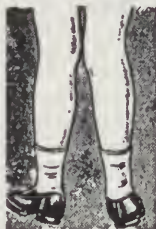
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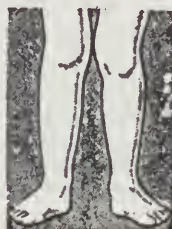
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Some authorities say the decline may be partly due to improved methods of birth control and liberalized abortion laws, while others believe the decline is related to the prevalent economic conditions, according to *Hospital Indicators*, an AHA report based on data from a representative sample of community hospitals.



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"The history of science, and in particular the history of medicine...is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

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Opinion

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Agree there is a significant
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24.9%

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I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalent

lency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

Clinical Predictability More Important Than Price

Although the question of price has been greatly exaggerated, it is true that patients can on occasion save money on generic drugs. But you are not going to dare attempt to save money if it jeopardizes the patient's health. Let's return to the example that has become very prominent in recent years, that of the cardiac glycosides. These are probably the most toxic drugs we use with respect to the small difference between a maximally effective dose and a toxic dose. When you are dealing with drugs of this type, the first concern must be clinical predictability. At the risk of variations in bioavailability, it would be sheer folly to try to save the patient what might amount to maybe \$10 or \$20 a year. The physician cannot manage his patient unless he is sure that the drug he is prescribing has the same positive effect each time the prescription is renewed. This is especially significant when the patient takes the product, not for months but for the rest of his life.

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minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

Newer Bioavailability Studies Reveal Differences

Although equivalence of different preparations of a drug substance may be defined by certain physical, chemical or biological characteristics, identity is not always assured even though these characteristics may be described in compendia such as the USP, NF or defined by other specific source standards. Moreover, even with equivalent drug substances, similar pharmaceutical products can be produced by different manufacturers such that these products are biologically or therapeutically nonequivalent.

A Growing Awareness of Potential for Nonequivalence

As experience increases with drug substances derived from different sources and under different conditions, it should be possible to establish specifications in sufficient detail to minimize the potential for their nonequivalence. However, there is general agreement that product therapeutic equivalence would still not be assured even if one could

lent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalence have appreciably improved.

Product Selection Based on Patient Response

Improved specifications and standards can better assure the equivalence of drug substances. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the drug product, not the drug substance, that the physician, pharmacist, nurse and patient-customer utilize. How can these indi-

viduals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Opinion & Dialogue

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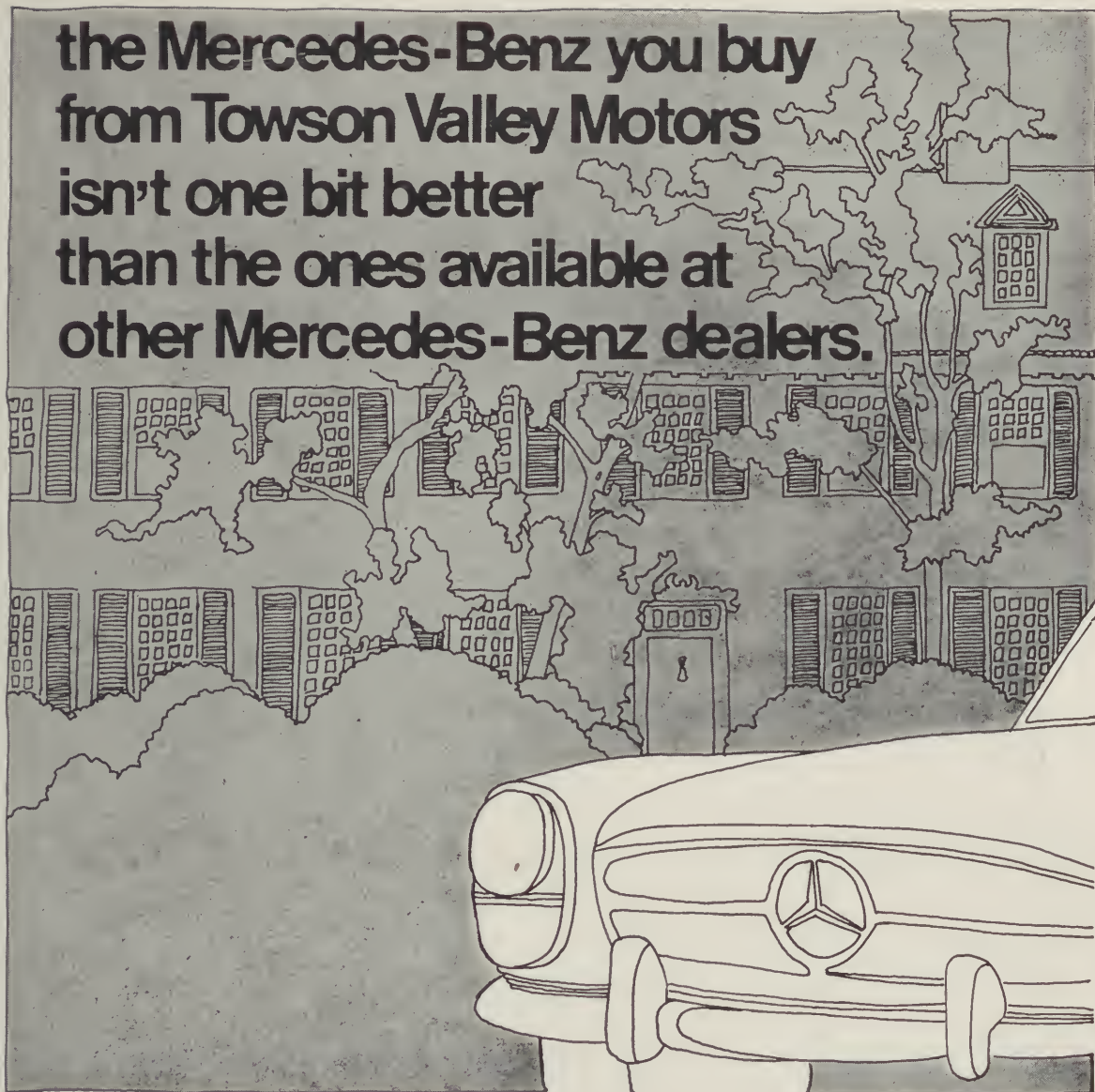
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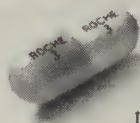
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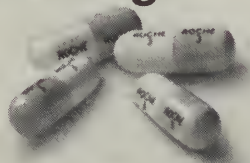
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

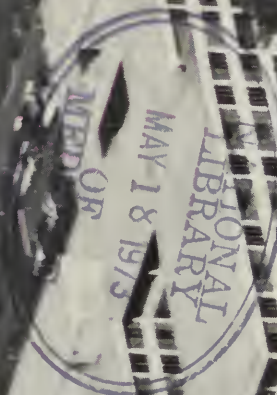
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Sally's back in sew biz! After an arthritic flare-up.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, using those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dose. Short-term relief of severe symptoms with the highest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions, symptoms of blood dyscrasia; dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; tonsillitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, extent of concomitant diseases, and concurrent potent therapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use only effective dosage. Weigh initially unpredictable effects against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias,

Butazolidin® alka Geigy

Each capsule contains:

100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis,

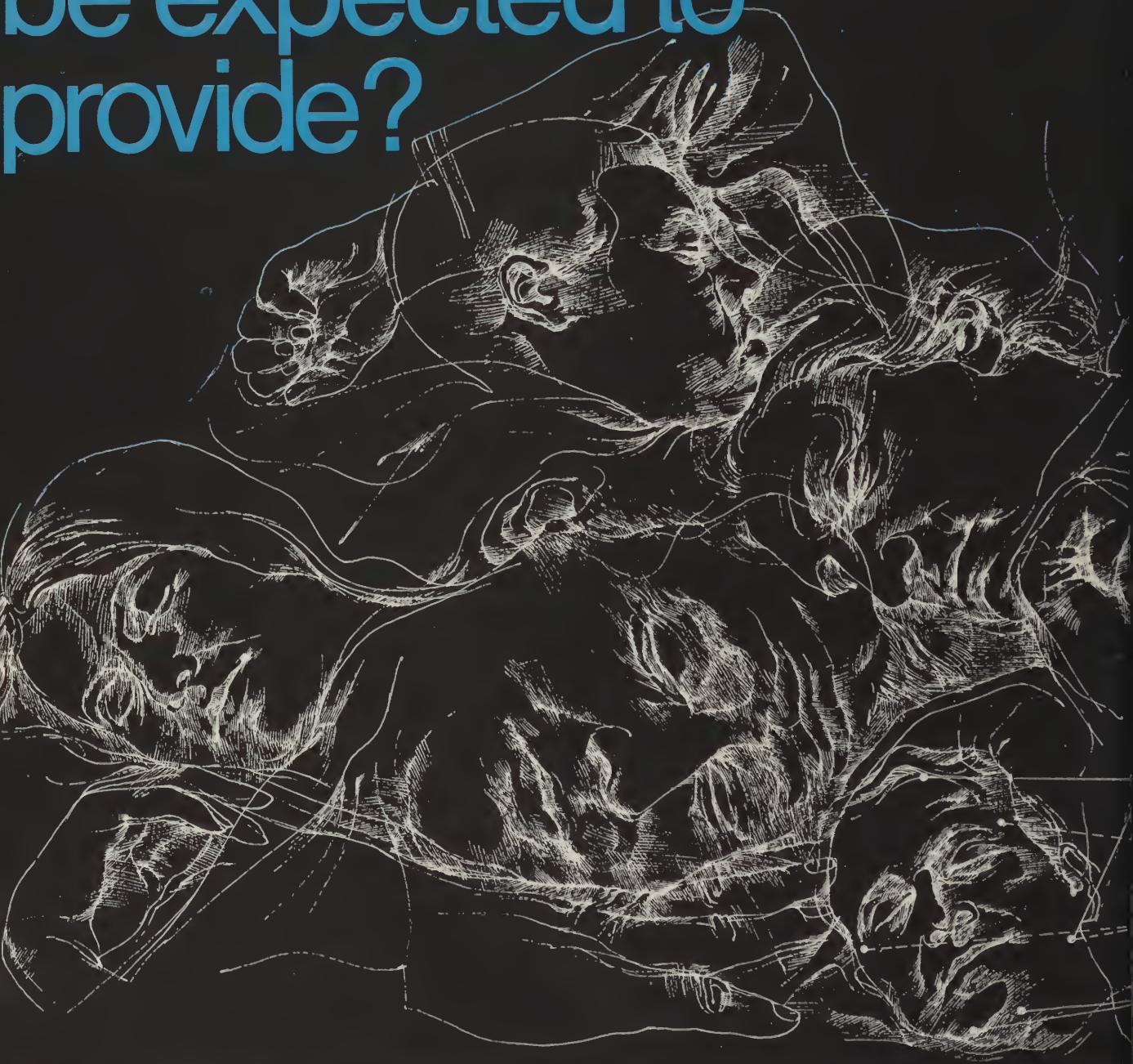
epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-070-G

Serious side effects do occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions.

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

What should a medication for sleep be expected to provide?



Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or

recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years

of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with

Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

Sleep with consistency

Dalmane (flurazepam HCl) has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane is in a class by itself. Not a narcotic, barbiturate or methaqualone, Dalmane is the only available benzodiazepine specifically indicated for insomnia.

Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. In most instances when adverse reactions were reported they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity agent proved effective and relatively safe for relief of insomnia.

DALMANE®

(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ent depression or suicidal tendencies.
periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe dation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech,

confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients.

Elderly or debilitated patients: 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

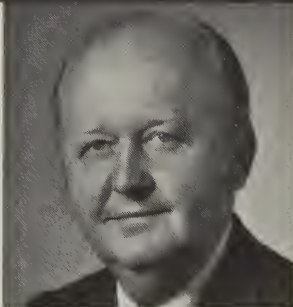
Dispenser of Medicine

Clifton J. Latiolais
President
American
Pharmaceutical
Association



Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical
Manufacturers
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25

ould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

er 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making free substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could allow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

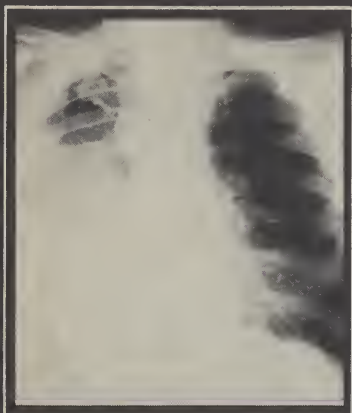
cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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64.8 mg. (gr. 1). *Warning—
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tablet also contains: aspirin
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caffeine gr. ½.

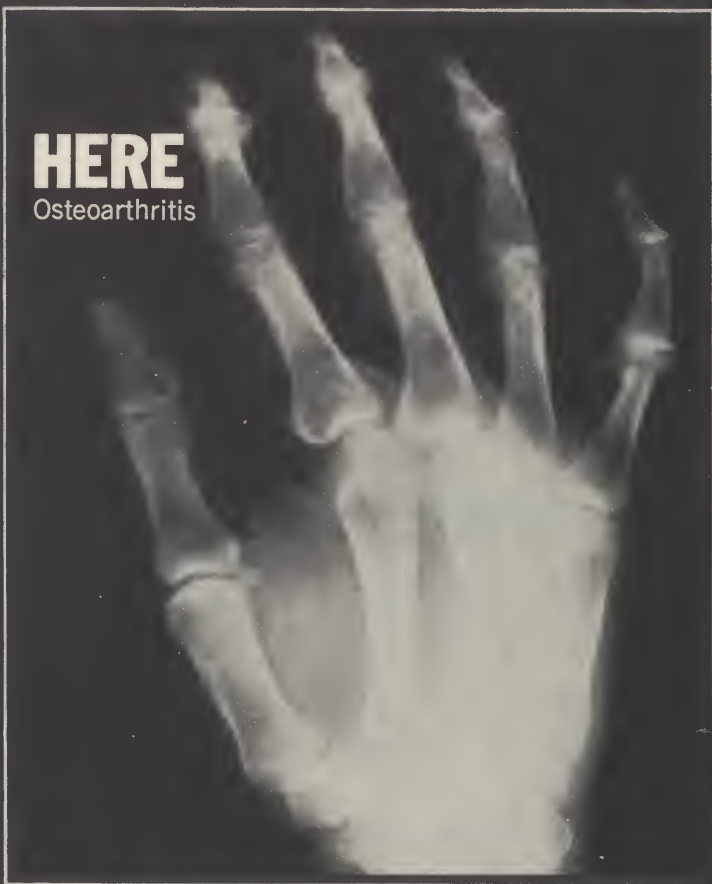


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Doctors take note...

MARYLAND AREA

- Jun 2-4 **Weekend with Doctors**, Frostburg State Col, Frostburg Md. Sponsor & Contact: Md Heart Assoc 201 N Charles St, Baltimore Md 21201.
- Jun 7-9 **Postgrad Crs on Intrauterine Development & Fetal Mgt**, Baltimore. Sponsor: Johns Hopkins Hosp. Contact: Dr J W Johnson, Dept of Gynecology & Obstetrics, Johns Hopkins Hosp, 601 N Broadway, Baltimore Md 21205.

AMERICAN COLLEGE OF PHYSICIANS

(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104.)

- Jun 4-8 **Hematology**, Univ of Washington Sch of Med, Seattle.
- Jun 11-15 **Oncology & Chemotherapy**, Univ of Southern Calif, Los Angeles.
- Jun 18-22 **Clinical Aspects of Blood Transfusion**, Michigan State Univ, East Lansing.
- Jun 25-29 **Advances in Internal Medicine: 1973 Perspectives**, Univ of Alberta & Univ of Calgary, Banff, Can.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

(For info on these mtgs, contact ASA, 515 Busse Highway, Park Ridge Ill 60068.)

- Jun 11-15 **Symposium: Basic Sciences Related to Anesthesiology**, Montefiore Hosp & Med Cen, Bronx NY.

MISCELLANEOUS MEETINGS

- June 1-2 **Laparoscopy: Indications, Technique, Anesthesia, Equip**, Seattle. Contact: Dr Kenneth Wilske, Div of Continuing Med Educ, Virginia Mason Med Cen, 1111 Terry Ave, Seattle Wash 98101.
- June **TAP Institutes**, Little Rock Jun 1-3, Rapid City SD Jun 15-17, Denver Jun 15-17. Sponsor: Joint Comm on Accreditation of Hospitals. Contact JCAH, 875 N Michigan Ave, Chicago Ill 60611.
- Jun 8-9 **9th Anl E C Hamblen Symposium in Reproductive Biology & Family Planning**, Durham NC. Contact: Dr C B Hammond, PO Box 3143, Duke Univ Med Cen, Durham NC 27710.
- Jun 14 **Amer Electroencephalographic Society**, 8th anl crs on Clinical Electroencephalography, Statler-Hilton Hotel, Boston. Contact: Dr D W Klass, EEG Crs Dir, Mayo Clinic, 200 Flrst St SW, Rochester Minn 55901. Their 27th anl mtg will follow Jun 14-15.
- Jun 22-23 **Emergency Dept Legal Institute**, O'Hare Regency House, Chicago. Sponsor: ACEP & Hlth Law Cen of Aspen Systems. Contact: R T Johnson, ACEP, 241 E Saginaw St, East Lansing Mich 48823.
- Jun 22-23 **Amer Assoc for Study of Headache**, anl mtg, Plaza Hotel, New York City. Sponsor & Contact: Amer Assoc for Study of Headache, 5252 N Western Ave, Chicago Ill 60625.
- Jun 23-24 **AMA Anl Mtg**, New York. Contact AMA, 535 N Dearbon St, Chicago Ill 60610.
- Jul 8-19 **Summer Program in Human Sexuality**, Bloomington Ind. Sponsor & Contact: Indiana Univ Institute for Sex Research, Morrison Hall 416, Bloomington Ind 47401.
- Oct 20-21 **1973 Certification Exams**, American Board of Family Practice, various locations. Contact: Dr N J Pisacano, Amer Board of Family Practice, Univ of Kentucky Med Cen, Annex 2, Room 229, Lexington Ky 40506. APPLICATIONS DEADLINE IS AUG 1.



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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Medical Miscellany

Nuclear Society Invites Membership

The American Board of Nuclear Medicine is an existing entity. Continuing education, public information, and specialty regulation are relevant issues, important to every physician in the practice of nuclear medicine.

To this end, the Maryland Society of Nuclear Medicine (MSNM) has been founded and is a component specialty society of the Medical and Chirurgical Faculty of Maryland.

Society objectives are to meet monthly for exchange of scientific information; review of medical journals and articles related to nuclear medicine; financial and social support of guest lectures; and receiving and holding dues, assessments, gifts, etc for use in education, research, and for publications in these fields.

President Theodore T Niznik MD, chief of the Department of Nuclear Medicine at Baltimore's North Charles General Hospital, invites interested physicians to join. He reports that membership is open to physicians who satisfy the criteria for the American Board of Nuclear Medicine eligibility or are already ABNM board-certified.

Meetings are scheduled for the last Thursday of each month, with exceptions of June, July, August, and December.

Dr Miznik reports that half of these meetings are devoted to journal review, problems in scantiphoto interpretations, etc, while the other half are dinner meetings at a local restaurant, with an invited lecturer speaking on a practical topic in nuclear medicine.

In addition to Dr Niznik as President, other officers are:

Vice President: Benjamin Rothfield MD, Dept of Nuclear Medicine, Perry Point VA Hospital

Secretary: Cliff Ratliff MD, Dept of Nuclear Medicine, St Agnes Hospital, Baltimore

Treasurer: George Agapitos MD, Dept of Nuclear Medicine, Maryland General Hospital, Baltimore



PROJECT HOPE—This photo was taken aboard the SS HOPE in Natal Brazil. It pictures **James R Appleton MD**, a Glen Burnie surgeon, then in service to the Baltimore-based ship of mercy, examining a ten-year-old Brazilian boy, reportedly dying of an overwhelming mastoiditis. Emergency surgery showed a large communicating brain abscess. The man next to Dr Appleton is Professor Raul Fernandes of the Department of Otolaryngology of the local medical school. The lady, Mrs Mary Lou Van Antwerp, served as interpreter. Dr Appleton speaks highly of his tour of duty and encourages more Maryland physicians to participate. The address: PROJECT HOPE, 2233 Wisconsin Ave NW, Washington DC 20007.

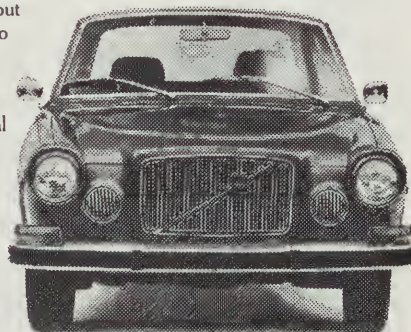
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MERITORIOUS AWARD was received by Dr Jerome Snyder, left, outgoing chief of the Maryland General Hospital Ear, Nose & Throat Department, Baltimore. The incoming chief, Dr Albert Steiner, is at the right. Dr Steiner was elected to a three-year term. Dr Snyder, the first chief, was feted at a special dinner in recognition of his dedication the course for the expanding future of the department.

South Baltimore General Hospital Gets \$25,000 from Auxiliary

A surprise visitor at the recent annual meeting of the Baltimore General Hospital's board of trustees was Mrs Raymond Miller Jr, President of the Women's Auxiliary.

She had been asked by the other members of the Auxiliary to present a check for \$25,000 to the board of trustees for the hospital's development program.

This represented a 25% increase over the previous year's contribution which was used to purchase beds for the hospital's new 42-bed unit.

Funds for these contributions come from Auxiliary operation of the hospital gift shop, which employs no paid personnel.

State has Health Films for Loan

To provide Marylanders with a complete listing of films that can be borrowed at no charge from its Film Library, the Maryland Department of Health and Mental Hygiene's Educational Services has developed a new publication, *Health Films on Loan*.

The catalog contains brief descriptions of all 16 mm sound films, sound and silent filmstrips, slides, audio-tapes, transparencies, and kits on many health subjects.

Materials may be reserved by writing their Film Services group at 301 W Preston St, Baltimore Md 21201, phone 383-2635.

Johns Hopkins School Of Health Receives \$3 Million Grant

The Robert Wood Johnson Foundation has awarded the Johns Hopkins University's new School of Health Services a \$3 million grant to educate new types of health practitioners.

The three-year grant, among the largest ever received by the University, was awarded to provide a new source of health manpower for primary health care needs.

The grant will be used to support a bachelor of science degree program for nurse practitioners and health associates. The program begins in September.

Students will enter the program at the third-year college level. The program will prepare them to perform a wide range of tasks associated with personal, family, and community health care in collaboration with other health professionals, such as physicians, nutritionists, nurses, and social workers.

As members of the health team, these health practitioners will be prepared to evaluate the health of an individual, provide preventive health care, and manage common acute and chronic illnesses in collaboration with other health specialists on the team.

About 50 students are expected to be enrolled in the two-year program in September, with the number increasing to 100 in 1974.

The students will receive clinical experience in the comprehensive health care programs associated with Hopkins Medical Institutions. Student selection will be based on previous academic work and experience in health-related fields. Nurses, ex-corpsmen, social workers, and college sophomores are expected to apply.

Dean of the School is Dr Malcolm L Peterson, formerly Director of the Johns Hopkins Health Services Research and Development Center in the Office of Health Care Programs. He is also Associate Professor of Medical Care and Hospitals at the School of Hygiene and Public Health and Associate Professor of Medicine at the School of Medicine.

In commenting on the grant, Dr David E Rogers, Foundation President said: "Dean Peterson combines a brilliant record in biomedical and clinical research with exceptional capabilities in research in health services and health sciences education."

National Health Council Continuing Education

The National Health Council, through its Committee on Continuing Education, announces ten short courses in 1973 for personnel of official, professional, and voluntary health agencies and organizations.

Course subjects include comprehensive health planning, consultation skills, community organization in health care services, executive development, leadership development, and the voluntary health agency in the community.

The courses are being conducted by seven universities through August including Columbia, Florida, George Williams, Indiana, Michigan, Oklahoma, and Washington.

Descriptive brochures and other information may be obtained by writing Continuing Education Program, National Health Council, 1740 Broadway, New York NY 10019.

PMA Foundation Grants

The Pharmaceutical Manufacturers Association Foundation reports that it is granting four new faculty awards to help stimulate research and teaching in clinical pharmacology and 23 "research starter grants" to postdoctoral investigators in schools of pharmacy, medicine, and veterinary medicine.

The faculty awards of \$200,000 are in salary and fringe benefit support for a two-year period beginning July 1. Support also continues for eight current recipients. Since 1967, 28 such awards have been made for more than \$1 million.

The 23 recipients of the research starter grants will each receive \$5,000 annually for two years. In addition, there will be 15 one-year continuations of awards made last year.

"The grants are designed to assist investigators starting their independent research efforts in the fields of pharmacology, clinical pharmacology, and drug toxicology," Thomas E. Hanrahan, Foundation Executive Director, said.

The PMA Foundation is financed principally by donations from US prescription drug firms. Since its inception in 1965, PMAF has awarded more than \$4 million for research and training.

American men now have a life expectancy, at birth, of 67.1 years, while that for women is 74.6 years. Average life expectancy at birth in 1900 was less than 50 years.

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DR BENJAMIN B BRUMBAUGH

One-of-a-kind Family Doctor

This PORTRAIT, authored by free-lance writer Jeanne B Sargeant, appeared in the Autumn 1972 issue of MARYLAND Magazine, Annapolis, Md. With their permission, it is reprinted here.

If Americana artist Norman Rockwell wanted a prototype of the kindly old family physician, he could end his search with Dr Benjamin Bruce Brumbaugh of Elkridge.

This November (1972) Dr Brumbaugh begins his 53rd year tending the ills of the 5000 people in this community southwest of Baltimore. It is unlikely, though, that the venerable doctor would even sit to pose, for he devotes seven days a week to his practice. For him, 60 hours is a short workweek, this in a time when younger men are enjoying a four-day, 40-hour week.

Elkridge knows it has a one-of-a-kind in 82-year-old Dr Brumbaugh. In fact, its inhabitants have expressed their appreciation of him with an elegant testimonial dinner. First there was the erection of billboards at each end of town which read: "Thank you, Dr Brumbaugh, For Over 50 Years of Care." Then came the dinner sponsored by the Rotary Club, with just about everyone in Elkridge participating, from the St Augustine teaching sisters, and priests, to the president of the bank; from babies he delivered three generations ago, to their grandchildren whom he more recently spanked into life. Even Vice President Agnew and Governor Mandel were on hand to pay their respects.

Dr Brumbaugh keeps many of his honors stashed away in a big paper shopping bag. There is the handsome leather scrapbook marked in gold, "Dr Brumbaugh's Children," filled with photographs of some of the thousands of babies he's delivered. (Only last year, at 81, did he give up obstetrics. He holds an honorary membership on the obstetrical staff of Bon Secours Hospital in Baltimore, where all of his deliveries were made.) There is the plaque from the testimonial committee, a letter from the Vice President, and many others. On the walls of his crowded office in the green clapboard house, where he has conducted most of his professional practice, hangs the citation from the Governor, naming him a Distinguished Citizen of Maryland, a page from the Congressional Record bearing a tribute from Representative Gude, and a number of plaques from appreciative fraternal groups. Down the street there is now Brumbaugh Avenue, in place of the old "Lateral Avenue."

Dr Brumbaugh grew up in Denton, Caroline County, across the Bay. His interest in medicine was sparked by his job in the local drug store as a youth. At the University of Maryland, he earned a doctorate in pharmacology (a degree no longer given), then worked his way through medical school as a druggist, graduating as an MD in 1916. He served briefly at old City Hospital in Bayview and at the University Hospital. After two years' service with the Army during World War I, he was



Dr Benjamin Brumbaugh

invited to assume the practice of then ailing Dr William Erickson in Elkridge. Dr Brumbaugh has been the medical omnipresence in the community ever since.

For 37 years he had a helpmate in his wife, Miriam Lee Smith, herself the daughter of a doctor. But she passed away in 1958. Since then, the indispensable Mrs Carrie Butler, whose housekeeping stay with the Brumbaughs measures just a decade short of his own long medical career, continues to keep the household going. Dr Brumbaugh is unequivocally devoted to his practice and his patients. His morning office hours start at eight; his evening hours end at nine. He makes afternoon rounds in the Mercury sedan presented to him at his testimonial dinner. It is a modern-day indulgence for a man who made his first bad-weather rounds with a horse and wagon, and later, in a Model-T Ford.

The doctor is not a loquacious man. He is of the old school. He has gentle manners and his approach to children is as courtly as to their elders. He is very fit, and obviously follows the good health tenets that he preaches.

On the other hand, he holds no truck with such modern time-savers as telephone-answering services, secretaries, or office nurses. He doesn't discuss the rates he charges or his attitude toward government in medicine. Some less devoted medical men would consider his office procedures antiquated. But his patients find in him the kind of general practitioner who lives only in the movies and in TV series. They feel that perhaps the mold for this kind of man has been broken.

Med-Chi Salutes

GREATER BALTIMORE MEDICAL CENTER

The Greater Baltimore Medical Center did not spring from the hillside (6701 N Charles St, Towson) without a distinguished history and medical tradition.

The medical center is the result of the merger of two specialized hospitals in downtown Baltimore: the Hospital for the Women of Maryland and the Presbyterian Eye, Ear, and Throat Charity Hospital.

From their foundings in the 1880s, the two institutions made outstanding contributions to patient care in their specialized fields. Looking to the future, both hospitals realized that the specialized hospitals could best serve the public and the individual patients through a complete-service medical center.

A formal merger of the two institutions took place and funds for the new hospital were raised. Over \$4 million, or two thirds of the equity, came from private funds.

Construction was begun in December 1963, and the Greater Baltimore Medical Center opened its doors on Sept 15, 1965.

Despite abandonment of the old-fashioned ward plan in favor of private and semiprivate rooms, free medical care forms a vital part of the service which GBMC renders the community. In Baltimore (1017 E Baltimore St), GBMC operates clinics as an integral part of the hospital's community service.

GBMC is an imaginative approach to the problems of supply, communication, nursing unit flexibility, and patient privacy. Innovations in design and appointment of this 400-bed facility are apparent at every turn.

The architects took advantage of a 60-acre sloping site to develop a rambling horizontal structure with grade-level access at each of its five floors. The main entrance is at the third level. One unit, mainly orthopedic, adjacent to the main entrance, gives patients access to public areas and to the outside. Total square footage is 311,000.

The kitchen, cafeteria, loading, storage, and central supply areas are housed on the fifth level. Two specially designed electric trains, that run on a spiral ramp within the building's core, dis-



tribute food and supplies to nursing and supply stations on the floors below.

Deliveries of records, laboratory specimens, and other smaller items are made to facilities within the core by an overhead basket conveyor system. Both systems substantially reduce the number of service and supply personnel normally needed to perform these functions.

The master plan calls for the addition of about 200 more beds to meet the needs of northern Baltimore's rapidly growing population. Offices and educational research facilities are also included in the master plan.

Among special services and facilities available to GBMC patients are these: Anesthesiology, Clinical Laboratory & Pathology, Gynecology, Ophthalmology, Otorhinolaryngology, Pediatrics, Medicine, Obstetrics, Psychiatry, Radiology, Surgery, Intensive Care, Physical Therapy, a 24-hour-day Emergency Room, and the East Baltimore Street Clinics.

Mr Paul O Becker is Executive Vice President; Mr Frank R Gabor is Director; and Everett S Diggs MD is Chief of Staff.

your medical faculty at work

by John Sargeant,
Executive Director

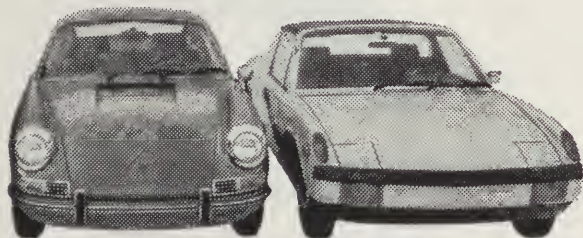
The Executive Committee met on Thursday, Mar 8, 1973 and took the following actions:

1. Authorized expenditure of \$150 to the Student AMA Chapter, Johns Hopkins University School of Medicine, for the purpose of defraying expenses of the students to attend the national meeting of this group.
2. Designated the following physician to represent the Faculty on the newly created City Commission on Aging and Retirement Education:
B Stanley Cohen MD, Baltimore
3. Determined not to take any further action in connection with medical students using the title "Doctor." This question arose because of a complaint in this regard. Neither of the two Schools of Medicine has a policy on this subject; and presently a statute is in the General Assembly making such action a violation of the Medical Practice Act.
4. Heard a report on the Maryland Foundation for Health Care and its recent contract agreement with the State of Maryland to review Medicaid Hospital Admissions.
5. Heard a report from the President-elect regarding the AMA Leadership Conference in Chicago that was both stimulating and informative. The President-elect was complimented for his presentation.
6. Heard a report from legal counsel that a physician is still covered for any acts performed by his subordinates involving blood banking, even though the FDA has ruled that collection of blood is not the practice of medicine.
7. Submitted the following names to the Secretary, State Department of Transportation, to act as advisors, if he so wishes, in connection with medical facilities at Friendship Airport:
Julius Loeb MD, Annapolis
Joseph I Berman MD, Baltimore
E Roderick Shipley MD, Linthicum Heights
Timothy Baker MD, Baltimore
Lt Col Donald Rosenberger, MC, MD, USA, Aberdeen
8. Agreed to request recommendations from both Montgomery and Prince George's County Medical Societies for appointment to represent the Faculty on a new Howard University Physician Assistant Advisory Board.
9. Designated John C Krantz Jr, PhD to represent the Faculty at the US Pharmacopeia Convention, April 14, 1973.
10. Designated Paul A Mullan MD to convey the views of the Faculty regarding restrictions in Howard County on Emergency Room Services which RPC has determined should only be provided at the Columbia Hospital and Clinic. The Executive committee concurred that this would violate the patient's right to his choice of physician.
11. If legal, has agreed to register the following names for possible use in the future:
Professional Standards Review Organization
PSRO Corporation
12. Agreed that Ipecac, during Poison Control Week, should only be provided free on the receipt of a prescription from the family physician.

13. Determined it would be a violation of Faculty Bylaws to accept two resolutions from Prince George's County Medical Society for consideration at the 1973 Annual Meeting, inasmuch as they were received on March 7, 1973 in an envelope dated March 5, 1973. The deadline for receipt of resolutions was March 2, 1973.
14. Granted approval to a letter-writing campaign to be sponsored by the Woman's Auxiliary involved Senate Bill 14 (US Senate), the Kennedy HMO bill.



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Baltimore City Medical Society

Drug Use and Abuse

DONALD M PACHUTA MD
Editor

DRUG ABUSE: A SELF-DESTRUCTIVE ENIGMA

CALVIN J FREDERICK PhD

Dr Frederick is Chief, Training & Research Fellowship Crime & Delinquency Center, National Institute of Mental Health, Room 12-C-04, 5600 Fishers Lane, Rockville Md 20852.

The opinions expressed herein are those of the author and do not necessarily reflect the views of the National Institute of Mental Health.

Information and reprint requests to Dr Frederick.

This and two subsequent articles will present new concepts about the nature of and approach to drug abuse problems.

The complexities of drug abuse are many but the problem is increasing in intensity perhaps more than in numbers. Some estimates have placed heroin addiction at about 300,000 in the United States.¹ However, some 590 million dollars were spent in 1965 for 167 million prescriptions by physicians for stimulants, sedatives, and tranquilizers. In 1967 about 20% of all prescriptions were for psychotropic drugs. It is the presence of mood-altering drugs such as amphetamines, tranquilizers, and LSD which makes the incidence of drug abuse greater than it was in 1900, when 1.5 million persons were addicted to narcotics.

The Harrison Act of 1914 required registration of all narcotics manufacturers and distributors, so that narcotics could not be used legally, except for analgesic purposes under medical supervision. An underground illegal supply system resulted, which caused a shift in the primary user population. Before that time, about two thirds of the users were white women in their forties, from middle and upper classes.² Then the most frequent users became male minority group members in urban ghettos. Four out of five users were from black, Puerto Rican, or Mexican backgrounds. Since 1960, young middle class whites have become users with in-

creasing frequency, so that there is now a greater socioeconomic spectrum than ever.

While so no single drug-abuse personality has been substantiated, it has been the belief of many clinicians that drug addicts, especially those on hard-core drugs, are depressed. This obtains as a rather pervasive feature cutting across a number of factors, imputed to the causality of addiction such as availability, alienation, rebellion, peer group pressure, social deprivation, and hedonism of sociopathy. Together with depressive features, self-destructive traits have been frequently seen as well. Until recently, however, these phenomena have not been validated in any systematic manner.

Mortality Incidence

The ratio of observed to expected deaths has shown male addicts to be 2½ times greater and females nearly three times higher than for comparable groups in the United States generally.³ Abelson⁴ affirms that from 1961-1969 drug deaths for persons of all ages more than tripled in New York City. He adds that deaths among young persons below the age of 24 years increased some five times during that same period. Furthermore, in that metropolitan area, drugs have been reported to be the most prominent cause of death for subjects between the ages of 15 and 35 years. Approximately one half of the heroin-related deaths, were found in persons not on the city's narcotics register.⁵

In taking data gathered from among the addict population from the Lexington Public Health Service Hospital, 5½% of the white males above 25 years committed suicide, compared with a figure of 0.7% of the white males of comparable ages in the general population. Slightly more than 1% of deaths from persons in the population as a whole are attributed to suicide. A study recently undertaken in the District of Columbia and suburban Maryland by

the author and associates indicates that 20% of the addicts have attempted suicide, which exceeds white controls of both sexes by 3½ times. Other aspects of this problem are developed in greater detail elsewhere by the author.⁶

Behavioral Congruencies With Suicide

There are many behavioral or psychological events which can be equated with actual suicide, some of which are conscious, while others operate below the level of full awareness. Illustrations may be seen in persons with serious respiratory ailments, such as emphysema, who continue to smoke heavily against medical advice; those with cardiac disorders who ignore the weight and dietary constraints; alcoholics who make no effort to alter their drinking patterns; chronic reckless drivers; and numerous individuals who engage in drug abuse. The majority of persons in these categories come in contact with physicians at critical points where appropriate intervention can make the difference between life and death.

While suicide is legally defined as a willful or self-intentioned act designed to effect one's demise, many workers in the field of crisis intervention and suicide prevention believe there are also subconscious or subintentioned deaths. Shneidman⁷ has suggested that there are three aspects to the dimension of intent in human deaths: intentioned, unintentioned, and subintentioned. With the intentioned type, the person acts in a direct and conscious manner to produce his own death. In unintentioned deaths the individual exerts no direct influence toward ending his life; it occurs independently from external physical trauma or internal biological failure. The subintentioned type, which is thought to account for the greatest number of deaths, is subliminal. Even though at a latent or unconscious level, the individual brings about his own death earlier than routine circumstances would allow. Poor judgment with risk-taking behavior occurs, which exceeds the bounds of ordinary discretion. Drug abuse usually falls into the latter category unless taken as a deliberate overdose by the victim. There is a Russian roulette quality to drug abuse, particularly with hard-core drugs. Addicts often knowingly use contaminated sources of drugs when others are available with little or no extra effort. A perpetual risk exists each time the drug is used.

Psychological and Physiological Aspects of Drug Abuse

When the arousal of tension is followed by an act which reduces that state to one of greater equilibrium or equanimity, the act becomes reinforced and is readily learned. The combined

physiological and psychological state of disequilibrium creates the climate for learning. Each time this circumstance occurs, the reinforcing act of addiction gains in strength. Any emotional state produces greater tension reduction and more rapid learning than one where this condition does not obtain.

The following paradigm represents the learning sequence: tension → addictive act → relief → shame, guilt → tension → addictive act. The cycle is then repeated. This explains why the use of either an antidepressant (energizer effect) or stimulant (tranquilizing effect) becomes conditioned. The so-called "highs" or "downers" both bring results in relieving tension and gain in strength as rewarding acts. The physician may not be doing the patient any favor to respond to his tension state by prescribing drugs. Even though the effectiveness can be dramatic, adaptation often brings a need for greater amounts of the drug on succeeding occasions.

Realistically, the physician may relieve his own anxiety about the patient, particularly if the person is suicidal, because the prescription brought relief and abated the suicidal crisis temporarily.⁸ However, without a thorough understanding of the complexities of the addiction and self-destructive behavior, both physician and patient may be asking for a more intolerable circumstance the next time the addictive suicidal state appears. Presumably, opioids suppress anxiety and bring on exhilaration, and barbiturates and other hypnotic, sedative drugs reduce the inhibition of drives by acting through the cerebral cortex. Each person requires a thorough psychological and physical evaluation to determine individual behavioral tendencies toward aggression and self-destructive behavior.

Diagnostic Symptoms in Suicide and Addiction

Since drug abusers of various types, including hard-core addicts, display depressive symptoms, it will be helpful to realize that this behavior often accompanies suicidal tendencies. The classical indicators of depression, which blend with suicidal trends, include 1) insomnia (especially early awakening for progressively longer periods), 2) anorexia (occasionally voracious appetite), 3) diminution in sex drive, 4) fatigability, 5) agitation, 6) irritability, 7) alterations in mood (sadness and/or inappropriate elation), and 8) apathy and isolation.

In addition to those signs, the following ones cited by Rathod⁹ et al are observable by the physician or collateral informants, such as family members: 1) rubbing of eyes and nose, 2) change in pupil size, 3) jaundice, 4) facial rash, often with scratching, 5) pyrexia for short

periods, 6) hostility, 7) blood-spotted clothing, 8) halting, slow speech, 9) indifference toward work and poor concentration, and 10) unexpected absences.

Self-destructive Indicators

Both *overt* or obvious factors, as well as more subtle or covert ones, are important to consider in assessing possible suicidal behavior. Overt, obvious signs consist of any direct comment about taking one's life; eg, ending it all, life isn't worth it; a burden to others, inquiring about death, such as leaving a body to a medical school, preparing insurance or wills; procuring a lethal instrument or medication; or a previous suicide attempt.

Covert, latent or subtle clues can be illustrated as follows: a recent loss, eg, of a loved one through death or divorce; job, or of a financial difficulty; school failure; a depressed attitude about the future; giving away a prized possession; self-abnegation; struggle with problems, such as addiction with feelings of helplessness and loss of hope; and virtually no personal or psychological resources in times of stress.

What the Physician Can Do

Besides becoming more astute to the signs of drug abuse and suicide previously noted, the physician can do much toward preventing loss of life with such persons. It will behoove the physician to assume a problem-centered orientation, rather than thinking pathologically and viewing the patient as mentally ill. There is little solid evidence, in fact, to support the concept that most drug abusers or addicts are mentally ill. The acute quality of the condition should be assessed with the possibility of hospitalization in mind. If the condition is acute, judgment may be poor and precautions should be taken to compensate for it. Patients may jump out of cars, attempt to drive when they should not, and attempt suicide soon after hospitalization.

Depression may also be present, which increases the possibility of suicide. If the depression changes from psychomotor retardation to any form of agitation, the condition is particularly dangerous. Curiously, this may develop in the addict after withdrawal is past. The physician should observe, listen, assess, and be fairly direct with the patient.

The addict will be sensitive to lack of honesty and initially may know his own medication needs better than anyone else. It will do no harm to ask directly about suicidal thoughts at an appropriate time during initial interview. Complaints should be taken seriously, especially if suicidal ideation is verbalized, since it may

represent a cry for help, so to speak. It is unwise to make penetrating interpretations about the person's behavior, during the acute phase, because this can heighten tension and precipitate some action which may be suicidal. The patient should be taught to bear the tension he feels without drugs, since drug-using behavior only continues to be reinforcing. Often a controlled and structured setting is necessary.

The patient should be assured that everything will be done to help him, while pointing out that his own assistance is needed, since he has to recognize the fact that the ultimate decision about his life is up to him. The patient's family should also be informed and their support solicited in not reinforcing undesirable behavior. Drug abuse, in general, as well as hard-core addiction, is more likely to yield in the long run to a broad approach which integrates changes in environment, style of life, and behavior patterns, together with drug usage itself.

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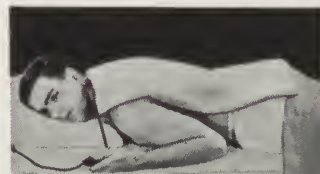
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executive director's newsletter

May 1973

NATIONAL AMBULATORY MEDICAL CARE SURVEY

A National Ambulatory Medical Care Survey is under way by the National Center for Health Statistics. The study is being conducted on a national basis among physicians providing ambulatory care in office practice settings.

The complete sample of 1,600 physicians, a few of whom may be in Maryland, is necessary for success of this project.

Any physician contacted in this regard is urged to cooperate to the fullest extent possible.

MED-CHI AND AMA EFFORTS

Through the cooperation of the Faculty and the AMA a change in the phraseology used for denial of certain benefits under Medicare has been accomplished.

The previous phrase on denial notices read:

REASON CHARGES NOT ALLOWED:
MEDICARE DOES NOT PAY FOR -
MEDICAL CARE NOT REASONABLE AND NECESSARY.

This has now been modified to read as follows:

REASON CHARGES NOT ALLOWED:
MEDICARE DOES NOT PAY FOR -
THIS MANY SERVICES FOR YOUR CONDITION
or THIS PROCEDURE FOR YOUR CONDITION.

Physicians are urged to let the Faculty office know whenever problems such as this occur so that action can be taken to rectify them.

Under discussion with state Medicaid officials is a recent ruling that requires physicians to take assignments for Medicaid patients also receiving Medicare benefits.

GENERAL ASSEMBLY ADJOURNS

In what many refer to as a lackluster session, the General Assembly adjourned at midnight on Monday, April 9, 1973, after a 90-day session that saw Chiropractors included under Blue Shield after a

20-year battle. It was obvious that the legislators were weary of hearing the issue of quackery raised and decided to dispose of it once and for all.

But to those who believe it is over, they can be sure that other bills equally dangerous to the public will follow. With success now in Blue Shield inclusion, Chiropractors are sure to ask for inclusion under Medicaid. The issue of "divide and conquer" is aptly borne out by the manner in which they attain their goals. State Health Department officials declined to oppose inclusion under Blue Shield but this group will be the ones under attack next year. Will Blue Shield come to their rescue then?

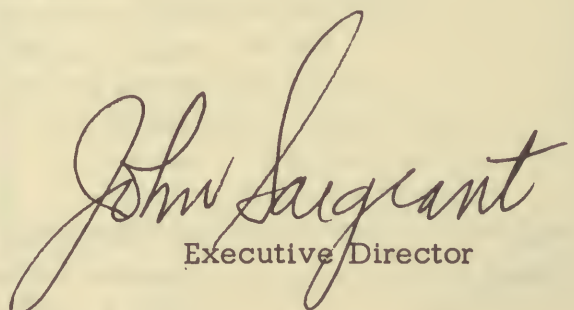
While the above issue can be considered a defeat for both Blue Shield and the medical profession, there were many other issues which the Faculty was successful in ensuring passage of necessary legislation; also in seeing that legislation was appropriately pigeonholed, or defeated on votes. Full details will appear in the windup issue of The Assemblyman. Be on the lookout for it.

ABORTION ISSUE

The General Assembly did not see fit to adopt new legislation dealing with the performance of Therapeutic Abortions -- particularly as they apply to the first trimester of pregnancy.

As a result, the onus falls on the profession for self-regulation. Plans are for ethical guidelines to be published governing the profession and, in particular, the performance of such procedures. Guidelines will establish certain minimum standards under which such abortions must be performed, outside of a licensed hospital.

Opportunity will be afforded all physicians in the state to comment on these regulations prior to their adoption by the Faculty's Council. If interested, let the Faculty office know so that a particular invitation can be extended for your input.


Executive Director

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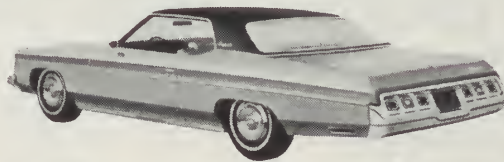
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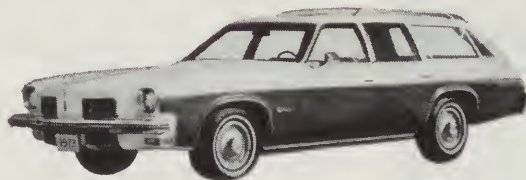
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Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water

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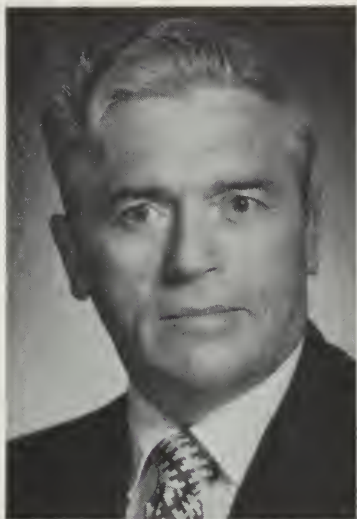
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Dr Toher

James E Toher MD, Catonsville, has been appointed chairman of the Department of Obstetrics and Gynecology at Baltimore's St Agnes Hospital.

In making the announcement, Sister Alberta DC, the hospital's administrator stated: "In his new capacity, Dr Toher is responsible for the medical administration of the Ob-Gyn Department and for the maintenance of the department's approved surgical residency which includes education and practice."

Dr Toher received his BS from Providence (RI) College and his MD from the Georgetown University School of Medicine.

He served both his internship and residency in Ob-Gyn at St Agnes and completed postgraduate training at Cook County Hospital in Chicago.

Allen J O'Neill MD was recently elected Chairman of the Medical Staff at Suburban Hospital, Bethesda. Other Montgomery County MDs elected included **Joel B Hoberman**, Vice Chairman, and **Hereward S Cattell**, Secretary-Treasurer.

Doctors in the News

Abraham M Schneidmuhl MD, Baltimore, has been awarded a Certificate of Achievement by the Commanding General of the First US Army for his contribution in the development and implementation of the First Army's Alcoholism Prevention and Control Program (the first such in the Armed Services), and for his outstanding work toward achieving a combined military-civilian effort in the prevention and control of alcoholism.

The Johns Hopkins University has announced two major administrative appointments. **Russell H Morgan MD**, Dean of the School of Medicine, has been named Vice President for Health Divisions. **Robert C Bowie**, Comptroller, has been appointed Vice President for Business Management.

Dr Morgan continues as Dean while coordinating the administration of the University's three East Baltimore divisions: the School of Medicine, the School of Hygiene and Public Health, and the new School of Health Services.

Randi Rubovits MD, a resident in psychiatry at the Psychiatric Institute of the University of Maryland Medical School, is the 1973 winner of the Taylor Manor Hospital Essay Award.

The \$250 award was made to Dr Rubovits when she delivered her essay, "Acute Intermittent Porphyria as a Biochemical Analogy for Acute Recurrent Schizophrenia," at the Fifth Annual Taylor Manor Hospital Psychiatric Symposium in Ellicott City on April 7.

Dr Marvin M Malcotti, a psychologist, has been named Superintendent of Rosewood State Hospital. He formerly served as Deputy Superintendent at Pennhurst State School, a facility for the mentally retarded at Spring City Pa.

Frank J Otenasek MD has been reelected President of the Medical Executive Committee of Baltimore's Bon Secours Hospital. **Anthony Hammond MD** has been elected Vice President and **Edward L Krug MD** is Secretary-Treasurer.

The Sinai Hospital of Baltimore medical staff has elected three new officers for 1973. They are **David M Solomon MD**, President; **Bernard R Shochet MD**, Vice President; and **Melvin M Friedman MD**, Secretary-Treasurer. Dr Solomon is Senior Attending Physician in OB-GYN and Director of Endocrine Research at Sinai.



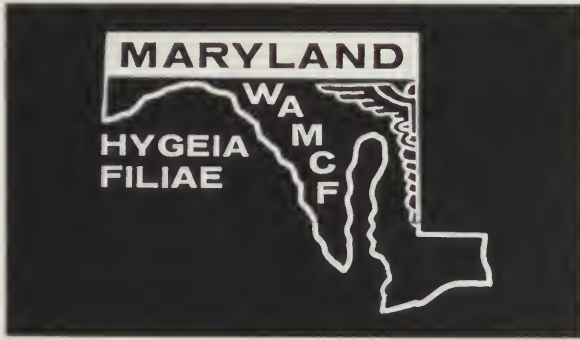
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MRS FREDERICK MILTENBERGER
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woman's auxiliary

PRESIDENT'S ANNUAL REPORT

The year has been a good one for the Auxiliary. We have experienced growth and development, building on our resources while daring to be innovative.

Our time-honored dedication to the raising of funds for medical students continues successfully. The substantial contributions of Faculty members to the American Medical Association Education and Research Foundation (AMAERF), coupled with our Auxiliary's fund-raising efforts, continues to be a source of pride to the Maryland medical community. Adding to the profits realized from the traditional sales of greeting cards and merchandise, some of the County Auxiliaries conducted garage sales and holiday auctions, gave swimming and exercise classes to profit the Fund, and generally employed the ingenious little ways that we women have of raising money. This year, too, working with the Faculty, we are selling "shares" for a Mexican Holiday, the winner to enjoy a free trip for two to Med-Chi's Semiannual Meeting in Mexico City in the fall.

In the political arena, we have kept abreast of federal and state legislation, pending and passed, which is affecting the practice of medicine. During the congressional campaigns this past fall, our members were availed of in-depth profiles of our Maryland candidates, and many of us worked actively for the election of candidates favorable to medicine's interests.

Ever mindful of the growing shortage of paramedical personnel, most of our County Auxiliaries worked closely with high school students interested in health-allied careers. In addition to providing financial assistance to deserving students, we worked closely in many communities with school guidance counselors. We have access to a great deal of information and publications describing various para-medical careers, the educational requirements for these careers, and the available aid to assist interested students in pursuing these careers—all of which was dis-

seminated on the county level. In many areas, highly successful hospital tours were arranged for interested students, during which they had the opportunity to speak with hospital personnel and to see, first-hand, the workings of the various departments in a hospital.

Throughout the State, our County Auxiliary members honored their husbands on Doctors' Day with special celebrations and splendid publicity.

Maryland's exhibit in New Orleans at the Southern Medical Convention last November took the first place award.

Our charitable concern does not stop at our nation's borders. We continue to ship much needed drugs, supplies, and medical publications overseas. In addition, we in Maryland have this year adopted a child of a physician practicing in a rural area of a foreign land. A child in this land, to be properly educated, must attend school in the city even while his physician father ministers to the sick in the hinterlands. The child's urban schooling, room, and board costs \$360 a year, a cost which we have assumed, so that the child's father is free to practice where he is needed while his child receives optimum education.

It is our pleasure to serve as advisors and to give some financial assistance to the delightful group of medical students' wives who have formed a chapter of the Woman's Auxiliary to the Student American Medical Association (WA-SAMA) at the University of Maryland. These wives of our future doctors are an intelligent, lively group who inspire confidence in the caliber of our medical community in the years to come. We look for an increasingly and mutually beneficial association with these young women.

Consistent with our concern for the health care needs of our citizens, many of our County Auxiliaries have been meeting community needs in the areas of health education and volunteer

health services. Our Auxiliary has access to excellent films and literature in the areas of drug abuse (particularly among elementary school age children), nutrition, personal safety on the streets, drunken driving, water safety, emergency resuscitation, blood donor programs, and the like. Many of our County Auxiliaries have assessed existing needs in their own communities and have been busy implementing appropriate educational programs for the local populace, always with the approval of their local medical societies, of course. This year, we restructured state committees to parallel those of the National Auxiliary in order to effect a more efficient channeling of this kind of educational material. Wherever possible, the counties have followed suit in their own committee makeup so that there is minimal delay in the implementation of necessary programs on the local (county) level which is, after all, where the real work is done. In addition, we have formed a Program Development Committee this year so that our projects will be ongoing from one year to the next.

At the suggestion of Dr DeLawter, the Faculty President, the Auxiliary is in the process of setting up guidelines for a committee to assist physicians' widows. We anticipate the existence, in each county, of such a committee, to be composed of members of both the county medical society and its Auxiliary, with a like committee on the state level to serve in an advisory capacity to the counties.

We are gratified to have had many doctors' wives join our ranks this year and we are so pleased to welcome these new members to our existing County Auxiliaries. We hope they will enjoy many years of fruitful association. In addition, Anne Arundel's Medical Auxiliary has had, we are happy to report, a very busy and productive first year. And this year, we look forward to welcoming our newest County Auxiliary, the doctors' wives of Howard County. This brings us to a total of 13 organized county medical Auxiliaries in our state.

Our members throughout the state have been kept abreast of the high points of our activities through the semiannual publication of our newspaper, *Hygeia Filiae*, a most entertaining and informative publication. We are grateful, too, for the opportunity of preparing a monthly column of our Auxiliary's activities for the *Maryland State Medical Journal*. We trust we have, through this means, kept the members of the Faculty informed of our various undertakings.

The culmination of our Auxiliary year, our Annual Meeting, was highlighted by two very important guest speakers. At our Thursday

luncheon, we were privileged to hear the President-elect of the AMA, Dr Russell B Roth. Dr Roth spoke to us on the contemporary posture of the AMA. Also visiting with us for this Annual Meeting was the very charming, delightful, and knowledgeable Mrs Norman Gardner, who is our Eastern Region Vice President of the Woman's Auxiliary to the AMA. She delivered the keynote address at our business meeting and aptly titled her remarks "You Are The Key."

The inclusion of the Auxiliary on the Faculty's Committee on Program and Arrangements is greatly appreciated and has resulted in a fine working partnership of our two groups. We are grateful, too, for the Faculty's financial assistance which has helped us immeasurably in carrying out our various programs. We are happy to again have sponsored the Annual Art & Hobby Show at the Annual Meeting and hope that many of you displayed your talents there. Space was also allotted to us in the Exhibit Area at the Civic Center for an Auxiliary booth depicting our activities. Doctor, we do hope you visited our booth and "Met Your Auxiliary." We'd like you to get to know us better.

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DANIEL V LINDENSTRUTH MD
Editor

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the heart page

SCREENING FOR HYPERTENSION

ELIJAH SAUNDERS MD

Dr Saunders is Chairman, Subcommittee for Hypertension Screening, Central Maryland Heart Association; Chief, Division of Cardiology, Provident Hospital; and Instructor in Medicine and Cardiology, University of Maryland School of Medicine.

Screening for hypertension has been done in various parts of the country over the past few years because of the increased importance of hypertension as a community and nationwide problem. Community hypertensive surveys have been made by Baldwin County Georgia, the National Health Survey, Alameda County Blood Pressure Survey, Peoples Gas Company of Chicago, Family Planning Clinics in Washington DC, the Health Department in New Orleans, and others.

The National Heart and Lung Institute is currently conducting a cooperative study in which Phase I of the project involves screening for hypertension among patients gathered from home surveys, industries, and public places such as shopping centers. Results of these projects are recorded in the medical literature.

Recently, the Cardiology Division at Provident Hospital has participated in two screening programs. The results will not be reported in detail at this time, but general information is available. During the City Fair held recently in Baltimore, a team from Provident Hospital screened "walk-ins" of all ages, races, and both sexes. The results generally indicated that, among about 300 patients screened, approximately 20% were referred to their usual source of medical care because of the finding of a blood pressure above 140 systolic and/or 90 diastolic. At the time of this writing, a screening program jointly sponsored by the following groups was being conducted in a large shopping center (Mondawmin) in West Baltimore in an area

that serves largely a black community. The participating groups: Central Maryland Heart Association, Provident Hospital, CIBA Pharmaceutical Company, Monumental City Medical Society, Baltimore City Medical Society, and the Maryland State Department of Health and Mental Hygiene. Several problems were encountered and the problems confronting most screening programs were brought to light. However, it was felt that a significant contribution was made to the health care of this community by such an endeavor.

The Subcommittee for Hypertension Screening of the Central Maryland Heart Association organized the screening program. The physicians and other members of the committee met with all participants in the program on a weekly basis for the four weeks leading up to the screening program. The participants included registered nurses from Provident Hospital, volunteer nurses of the Heart Association, and other volunteers of the Central Maryland Heart Association. The classes were conducted at Provident Hospital and included orientation on the general subject of hypertension, the measurement of blood pressure, and the significance and objectives of a screening program. The nurses were paired with a volunteer to aid in the teaching of the measurement of blood pressure, and these two were to function at one of the stations at the screening booth during the actual screening.

These types of sessions contributed to much enthusiasm and compliance on the part of all persons concerned which made for a very suc-

cessful program. Publicity was handled by the members of the subcommittee whose expertise is in this area and the services of local television, radio, and news media were obtained. Television spots about high blood pressure and the screening program included a prominent sports figure and were aired for several days prior to the actual screening program.

Detailed analysis of the data cannot be reported at this time but the screening team saw approximately 550 to 600 patients per day during the first four days and close to 1,000 patients on the fifth day. The unofficial count showed that 3,279 patients were seen during the five days of screening. Although the area served by the Mondawmin Shopping Center is mostly black, persons came from all over the city and a number of these persons were white. The youngest person screened was age ten and the oldest is not known at this time but several persons were seen in their 70s.

The unofficial count showed that 601 persons were referred because of the finding of a diastolic blood pressure above 94 mm of mercury. This level of blood pressure was used as the cutoff for referral because of reasons noted below. However, it is estimated that if the cutoff blood pressure was above 140 systolic and/or 90 diastolic, the number of referrals would have been about doubled. Thus, with the cutoff of 95 mm of mercury, approximately 20% of the persons screened were referred to their primary source of medical care (mainly their private physicians) for rescreening, evaluation, and/or treatment. Exact figures are not available at this time but it was the subjective impression of the screening staff that a large number of persons seen were, indeed, under treatment for blood pressure and identified a private physician or a medical source for usual care of their blood pressure.

Statistical data must await detailed analysis of all persons screened. However, some attention must be given to the responsibility of the professional in terms of adequate knowledge to handle the chronic hypertensive. Forms were completed and given to the patient with elevated blood pressure to be given to his physician who will mail a copy to CIBA in order to determine if the patient was seen.

Hypertension is probably the most common chronic condition encountered by the practicing physician in this country. It is estimated that 10-15% of the American adult population have elevated blood pressures. Thus, approximately 22 to 24 million people are afflicted with this malady. Furthermore, it is recognized that approximately half of the people who have hypertension are

unaware of it; of this group, approximately half or less are under inadequate treatment and, therefore, noncontrol of their blood pressure. Many factors are responsible; it is not proposed at this time to go into all of them, but rather to talk about the importance of screening, the need for early referral, the need to improve patient compliance, and finally to prepare the practicing physician and other sources of medical care to efficiently and effectively handle the patients resulting from screening.

It has been well-publicized that the recent cooperative study done by the Veterans Administration pointed out without question the benefit of treatment of at least moderate to severe diastolic hypertension. Arguments continue on whether or not the long-term treatment of mild hypertensives or labile hypertensives is beneficial. But it seems there is no question that, at least in males, the treatment of diastolic hypertension in the moderate-to-severe range will decrease significantly the mortality and morbidity statistics that are quite high in the nontreated patient.

Several major problems are presented when one engages in a screening program for high blood pressure. Review of the literature reveals that screening programs can be carried out among the following groups:

- 1) Inviting a large portion of the population to a screening facility by mass media publicity as well as sending individual letters to households inviting persons to come in for screening.
- 2) Door-to-door screening may be carried out by screening teams.
- 3) Screening facilities may be set up in any community where people congregate, such as a shopping center.
- 4) Persons referred to a hospital, either for admission or upon presentation at an outpatient facility, may be screened for hypertension while they are being seen for other problems.
- 5) Screening may be carried out in any large industrial population, convention, or church gathering.

According to Doctors Wilber and Barrow, numerous problems result from all of these methods. They have found that in the mass media publicity technique, as well as individual letters to households, the response rate is very low. In their experience, only 10% of the target adult population was interested enough to come to the central headquarters for a "free" blood pressure measurement and these were mainly the elderly or those already receiving treatment for hypertension. They further pointed out that the door-to-door techniques or the use of mobile screening vans where people naturally congre-

gate, were found to be among the most successful methods.

Door-to-door screening, in their experience, was difficult physical work, however, and approximately 40% of the households screened by this method yielded at least one interview. However, they stated that in 18% of the households in which someone was found at home, the person contacted refused screening; in 50% of the households, no one was found at home on at least two visits. The door-to-door method found somewhat older people at home and fewer men as compared with the census data. Again, the mobile van or clinic setup at shopping centers proved to be the most efficient and effective way to reach a representative group of the population. The largest number of interviews could be obtained in the shortest time and the age and sex distribution was quite similar to the census figures. However, many people outside of the study area were inadvertently screened causing difficulty in the resurvey and follow-up.

Final comments concern two of the major problems encountered in screening for high blood pressure. First is the establishment of screening criteria that will not result in unnecessary referrals or worry among the patients as well as their physicians in a given community. Thus, the cut-off levels for hypertension must be defined according to the age of the persons and whether or not there is a previous history of known elevated blood pressure. Again, referring to the screening program of Doctors Wilber and Barrow, their single criteria of pressure for referral was greater than 160 mm systolic or equal to or greater than 95 mm diastolic for all ages. In spite of this, because of the lability of the arterial blood pressure, many of these patients (approximately 20%) were found to be "normotensive" when rechecked by the physician. Additionally, one wonders if, when the patient is referred to this physician for "rescreening," whether the patient and the physician may assume that the "screening experts" are saying that such a person should be treated.

This brings up the second major problem of professional education as to the significance of the screening program, the criteria used for referral and the indications for further evaluation and treatment. Screening teams must be concerned with what happens to the patient once he is referred to his physician. Possibly heart associations, local medical societies, medical schools, and health departments may need to address themselves to this problem and come up with effective ways of helping practicing physicians to cope with it. The increased volume of patients


"dumped" on the already overloaded medical system must be completely assessed and appropriate solutions found to these additional problems.

In spite of these problems, it is the opinion of this subcommittee that improved and effective screening programs are indeed a necessity. Furthermore, it has been recognized for a long time that blacks have an increased prevalence of hypertension and tend to do worse once they have the disease than do nonblacks. Complications seem to occur earlier and treatment sometimes is less effective. Thus, it is appropriate in large metropolitan areas where there is a great concentration of black persons that the various social and medical agencies be concerned with finding new, undetected, or uncontrolled cases of hypertension and find means by which they can be treated.

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EDITORIAL

More than ten years ago, Dr George G Finney Sr and the late Dr Amos R Koontz called together physicians representing all sections of the State for the purpose of forming the Maryland Medical Political Action Committee. Physicians at that time realized their future was in the hands of men other than their own ranks and, after 30 years of activity by various other political action groups, physicians were organized also.

During this ten-year history, hundreds of hours have been devoted to the study of philosophies of the men seeking political office, especially in the US Congress. These hours have been spent in interviewing candidates seeking office such as US Congressman and US Senator. They have come willingly to be interviewed for the name of the game is support by organizations such as MMPAC. Support means dollars with which to conduct their campaign; support means endorsement by the political action groups before which they appear; support means volunteers and the thousands of man-hours needed to staff and operate an effective campaign for their election.

In the most recent election, MMPAC activity supported candidates in six Congressional Districts, five of whom were successful in their office-seeking goal.

While MMPAC activities may appear to be selfish in their motives, they really are not. For years, the physician's concern has been that of the

patient. In his community involvement (hospital planning and patient care—fund drives for worthy community projects and institutions—time and energy devoted to religious, historical, art and musical groups—teaching services in medical institutions—supervision of new physicians in operating rooms, clinics and patient care),

he has consistently placed the patient's interests ahead of his.

Political action activity is just an extension of this involvement. Important as the others are, without political action, they will be "as a tinkling brass and a sounding cymbal." As we look ahead to the next ten years, we express our appreciation to those who have led us before: Doctors George G Finney Sr, Howard F Kinnamon, William T Layman, Joseph H Hooper Jr, George G Finney Jr, DeWitt E DeLawter.

May we become more involved and exert an even greater influence in years to come.

The AFL-CIO Committee on Political Education (COPE) spent at least \$2.8 million and mobilized 100,000 campaign workers in the 1972 congressional elections. It is now gearing up a huge effort, in its words, "to improve the Congress" in 1974.

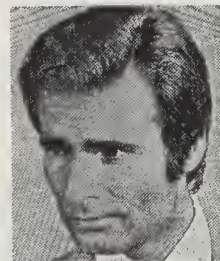
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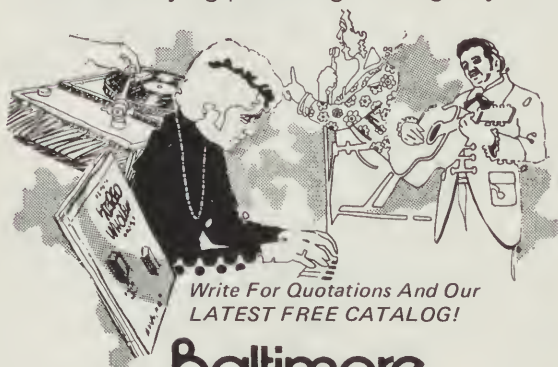


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Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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*Koch-Weser, J., et al.: Arch. Intern. Med., 128:399, 1971.

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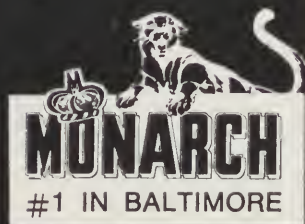
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CAVEAT VENDITOR

This editorial appeared in the Baltimore News-American on March 3, 1973 and is reprinted here with their permission.

There are disturbing signs that Maryland may be moving in the direction of government intervention in provision of health care.

Hospital beds lying empty cost an average of \$19 added to the patient's bill.

A decision about which Baltimore city hospital ought to extend services to hospital-shy Howard County goes one way one day and another way the next, raising the specter of protracted litigation before Howard gets a needed facility.

Labor has criticized Blue Cross, charging lack of aggressive innovation and weakness of the consumer voice in policy making.

Medicaid, already costing near \$100 million annually, is expected to rise to \$150 million annually in the near future.

These portents deeply affect the health and lives of Marylanders. People may die needlessly if they deny themselves medical care because they cannot afford it.

Whenever private initiative fails to provide an essential service the only recourse is to turn to government either to regulate the provider or provide the service.

In no other field does confidence in the provider have a greater effect on the consumer than in the matter of health care.

No one wants to be denied the opportunity to pick his own provider. If the apparent drift is permitted to continue, if costs continue to escalate beyond the already burdensome cost-of-living increases, the rigid hand of bureaucracy may have to be interposed between the patient's free choice and the provider's best judgment.

Caveat venditor!

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Indications: Santyl Ointment is indicated for debriding dermal ulcers and severely burned areas. In other types of necrotic skin lesions reports on the use of Santyl Ointment have been limited to clinical observations without controls.

Contraindications: Application is contraindicated in patients who have shown local or systemic hypersensitivity to Collagenase.

Precautions: The enzyme's optimal pH range is 7 to 8. Lower pH conditions have a definite adverse effect on the enzyme's activity, and appropriate precautions should be taken.

The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme. Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

The ointment should be confined to the area of the lesion in order to avoid the risk of irritation or maceration of normal skin.

A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as Lassar's paste.

Since the enzyme is a protein, sensitization may develop with prolonged use although none has been observed to date.

Adverse Reactions: Adverse reactions to Collagenase have not been noted when used as directed.

Dosage & Administration: Santyl Ointment should be applied once daily (or once every other day in the case of outpatients) in the following manner.

(1) Prior to application the lesions should be gently cleansed with a gauze pad saturated in normal saline, buffer (pH 7.0-7.5) or hydrogen peroxide to remove any film and digested material.

(2) Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate topical antibacterial agent. Neomycin-Bacitracin-Polymyxin B (Neosporin) has been found compatible with Santyl Ointment. This antibiotic should be applied to the lesion in powder form or solution prior to the application of Santyl Ointment. Should the infection not respond, therapy with Santyl Ointment should be discontinued until remission of the infection.

(3) Santyl Ointment should be applied (using a wooden tongue depressor or spatula) directly to deep wounds, or, when dealing with shallow wounds, to a sterile gauze pad which is then applied to wound. The wound is covered with sterile gauze pad and secured with clear tape or Kling bandage.

(4) Crosshatching thick eschar with a #11 blade is helpful. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors.

(5) All excess ointment should be removed each time dressing is changed.

(6) Use of the ointment should be terminated when sufficient debridement of necrotic tissue has taken place.

Overdose: Action of the enzyme may be stopped, should this be desired, by the application of Burow's solution U.S.P. (pH 3.6-4.4) to the lesion.

How Supplied: Santyl Ointment contains 250 units of Collagenase enzyme per gram of white petrolatum U.S.P. The potency assay of Collagenase is based on the digestion of undenatured collagen (from bovine Achilles tendon) at pH 7.2 and 37° C. for 24 hours. The number of peptides cleaved are measured by reaction with ninhydrin. Peptides released by a trypsin digestion control are subtracted. One net Collagenase unit will solubilize ninhydrin reactive material equivalent to 4 micromoles of Leucine.

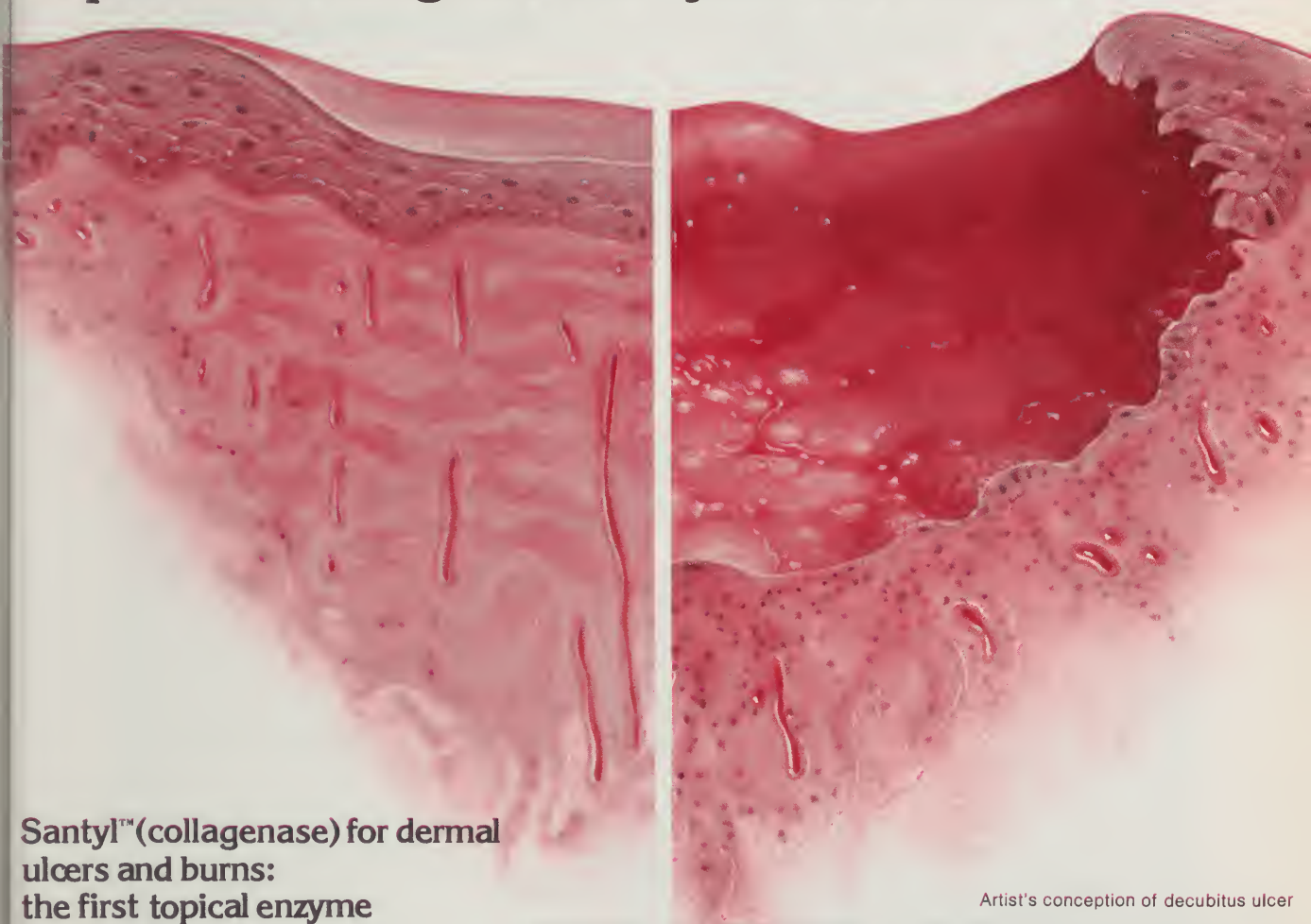


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Varma A O et al: *Surg. Gynec. Obstet.* 136:281, Feb. 1973.

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PERCUTANEOUS LIVER BIOPSY

A Review of 200 Cases

N C R W REID MB MRCP
MARVIN M SCHUSTER MD

First introduced by Ehrlich (1883) and Lucatello (1895), percutaneous liver biopsy attained widespread acceptance in the 1930s and 1940s.¹ In 1958 Menghini² described a new type of needle, which because of its small size and the short intrahepatic phase of the biopsy, has proved safer than those previously used. It is the purpose of this investigation to review the results of 200 liver biopsies performed with the Menghini needle at a municipal hospital. This report will:

1) Analyze the relative incidence of diseases which prompted the use of liver biopsy.

2) Analyze the information gained by biopsy in these clinical conditions.

3) Assess the mortality and morbidity of this technique when performed predominantly by the Resident House Staff.

4) Evaluate the significance of hepatomegaly and abnormal liver function tests in obtaining a positive diagnostic yield from biopsy.

Materials and Methods

Two hundred successive liver biopsy cases were analyzed for the following information: age, sex, and race of patients; the clinical condition prompting liver biopsy; whether this condition was confirmed or altered by biopsy; the presence of liver enlargement; liver function tests (alkaline phosphatase, transaminase, bilirubin, and

bromsulphthalein excretion) at the time of biopsy.

Results

Of the 200 patients, 60% were male (60 Negro, 51 White); 40% were female

(54 Negro and 27 White). Age distribution of patients of the time of biopsy is shown in Fig 1. Fig 2 shows the overall distribution of the liver biopsy results. Biopsies were diagnostic in 50%, but in only 12% of this group (6% of overall group) was the diagnosis altered by the biopsy. Twenty-three percent were histologically normal and 22% showed nonspecific changes. In approximately 5%, no liver was obtained at biopsy.

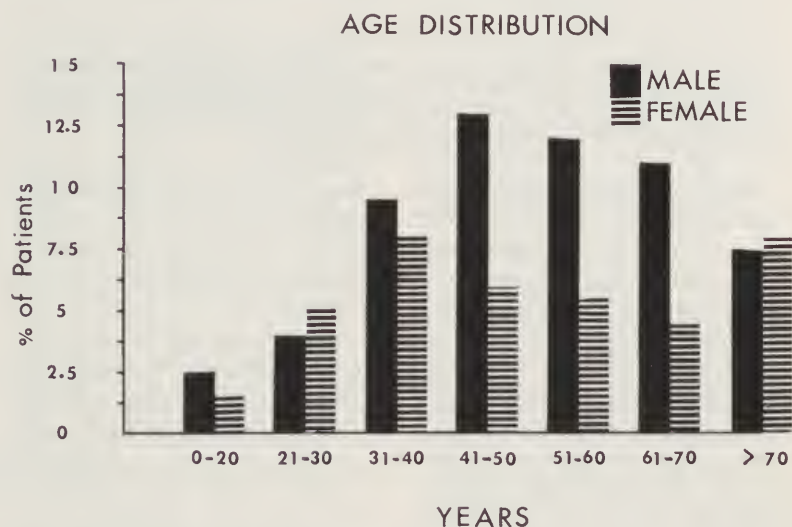


Fig 1: Age distribution at time of liver biopsy.

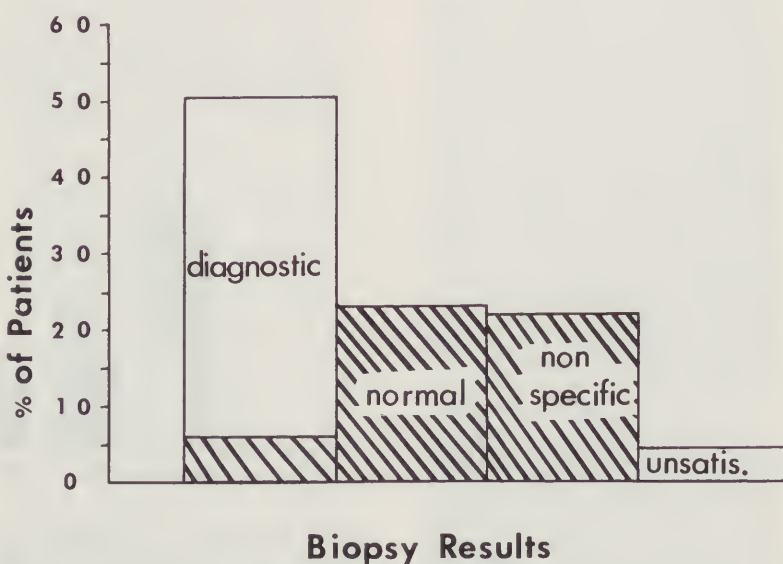


Fig 2: Distribution of liver biopsy results. Cross hatching indicates unsuspected findings.

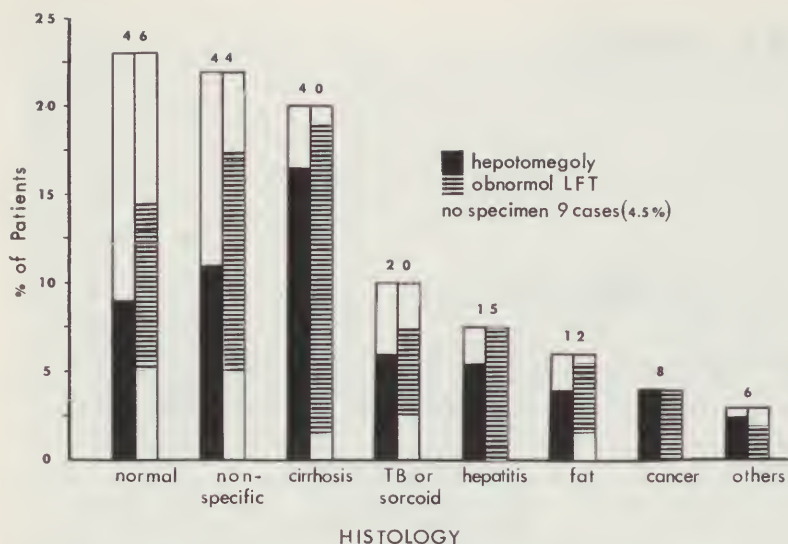


Fig 3: Distribution of hepatomegaly and abnormal liver function tests within the various categories of histological diagnosis. Areas of overlap between solid and cross-hatched bars indicates cases with both hepatomegaly and abnormal liver function tests.

Fig 3 demonstrates the distribution of hepatomegaly and abnormal liver function tests within the various categories of histological diagnoses. More than half the patients with normal liver biopsy had either liver enlargement or abnormal liver function. All patients with biopsy proven hepatitis had abnormal liver chemistries but only three fourths had liver enlargement. Histological evidence of cancer was found **only** when both hepatomegaly and abnormal liver function were present. Aside from normal and nonspecific biopsy findings, the diagnosis most often encountered when both liver size and function were normal was granulomatous disease, indicating the value of liver biopsy to detect granulomatous disease even in the absence of liver abnormality.

Results of liver function tests were analyzed to determine the percentage of diagnostic biopsies in patients with derangement of specific liver function tests. Patients with liver function abnormalities were further subdivided

into groups with and without hepatomegaly to ascertain whether the biopsy yield is different in these two groups (Fig 4).

The least useful test was the alkaline phosphatase. When alkaline phosphatase was elevated without any

other abnormality of liver function the biopsy was diagnostic in only one third of cases (1st pair of bars). Almost all diagnostic biopsies associated with elevated alkaline phosphatase were also associated with hepatomegaly (overlap of solid and hatched bars). When the liver was not enlarged only 1% of patients had diagnostic biopsies.

An isolated abnormality of transaminase, bilirubin, or BSP was associated with a diagnostic biopsy in 62% to 75%. The yield was not increased when combined abnormalities of alkaline phosphatase and transaminase were present. However, the highest yield (82%) was obtained when alkaline phosphatase, bilirubin, and transaminase were all abnormal. No matter what the chemical abnormality, the biopsy yield was always highest when hepatomegaly was also present (as indicated by the overlapping areas of the solid and hatched portions of each pair of bars).

ABNORMAL CHEMISTRIES

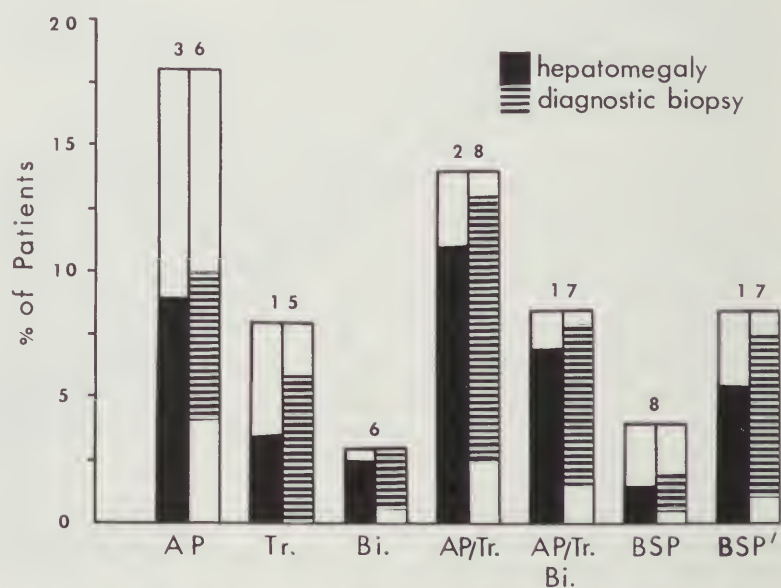


Fig 4: Distribution of abnormal liver function tests subdivided into groups with or without hepatomegaly and with or without diagnostic biopsy. Overlap of solid and cross-hatched bars indicates cases with both hepatomegaly and diagnostic biopsy.

Complications

Complications occurred in 3% of the 200 biopsies. Renal tissue was obtained in two, but in neither case were there any adverse consequences. Significant bleeding diagnosed by paracentesis occurred in two patients. Both ultimately recovered, but both required extensive transfusions and laparotomy.

Two postbiopsy deaths occurred, each in patients with evidence of biliary tract obstruction. One was an 84-year-old male gravely ill with obstructive jaundice of severe degree assumed to be due to carcinoma. Prothrombin time was 19% of normal. The patient died six days after biopsy, having become delirious on the second postbiopsy day and comatose on the fourth. Carcinoma was not proven by biopsy. Autopsy was not obtained.

The second patient had evidence of increasing abdominal distension and pleuritic pain following biopsy. She died 15 days after biopsy and at autopsy was shown to have generalized peritonitis, subhepatic abscess, and also a carcinoma of the ampulla of Vater.

Alcoholism

An alcoholic history was present in 40% of patients (75% males and 25% females). Twelve percent of patients with a history of alcoholism were subjected to biopsy solely because of this history. The remainder were biopsied because of suspected associated conditions such as cirrhosis and tuberculosis. Of the ten patients with only alcoholism as the suggested diagnosis, two had both hepatic enlargement and abnormal liver function. Both patients with hepatic enlargement had fatty livers on histological ex-

amination. Of the eight patients without hepatic enlargement three had fatty livers, three had normal biopsies, and two had nonspecific changes.

Discussion

In this series liver enlargement was as likely to be associated with a positive biopsy as was a functional abnormality. In 101 patients with a positive biopsy 75% had liver enlargement and 75% had abnormal liver chemistries compared with 45% of the 90 patients who had normal biopsies or nonspecific changes in association with hepatomegaly or abnormal functions. Sixty-four percent of patients with a diagnostic biopsy had both liver enlargement and abnormal liver chemistries compared with only 22% of those with normal or nonspecific changes.

Patients with cirrhosis constituted the largest group (20% of the entire series) in whom the biopsy was diagnostic. This is partly explained by the high incidence (44%) of a significant alcoholic history in the whole series. Only 5% with cirrhosis had both normal liver size and function, whereas the majority (88%) had both liver enlargement and abnormal liver function. One of the cirrhotic patients was not clinically suspected of having this condition and one patient with clinically suspected cirrhosis was shown to have sarcoidosis on biopsy.

The condition detected by biopsy which was least often suspected clinically was that of fatty infiltration of the liver. Six percent had appreciable fatty infiltration and a larger number were classified as nonspecific because only minimal fatty changes were present. Only two patients appear to have been suspected

of having this condition. The very low clinical suspicion of fatty liver is in agreement with Fisher³ who found a high incidence of fatty livers in patients suspected of having cirrhosis. On the basis of histology the diagnosis was changed from clinically suspected cirrhosis to the more benign condition of fatty metamorphosis in four cases.

Although hepatitis was clinically suspected in the differential diagnosis in 60% of the patients biopsied, there was a surprisingly low incidence of histological diagnosis of hepatitis in this series (7.5%). This is probably due to the fact that biopsies are not often performed to confirm the suspicion of hepatitis unless the diagnosis is in doubt.

Cancer in the liver was suspected in 20 patients and proven by biopsy in eight, all of whom were considered unequivocally to have hepatic metastases. No diagnosis of cancer was found without being suspected.

One of the most striking features of this survey is the high incidence of normal histology or minor nonspecific abnormalities found by liver biopsy. In only one half of patients did the biopsy contribute to a positive diagnosis, although the demonstration of normal histology or nonspecific changes altered the presumptive diagnosis in another 45% (Fig 2). Fisher and Fallon³ reported a positive biopsy in 66% of 341 patients and in the series described by Schiff⁴ the clinical diagnosis was confirmed in 50% of patients and unsuspected disease was revealed in only 2.5%. In our study unsuspected disease (usually fatty liver) was demonstrated by biopsy in 6%. A 23% in-

cidence of normal biopsies compares closely with the findings of other workers^{5,6} as does the demonstration of nonspecific changes in 22%.^{3,4,7}

Forty-four percent of patients with a normal biopsy had the biopsy performed in order to rule out hepatic tuberculosis and 10% to exclude carcinoma in the liver. Two of five patients with suspected carcinoma had normal biopsies but were subsequently shown to have malignancy in the liver. A high proportion (37%) of patients with normal liver biopsies had neither liver enlargement nor abnormal liver function and only 17% had both hepatic enlargement and some abnormality of liver function.

From these observations it appears that the presence of a normal-sized liver with normal liver functions is most likely to result in a normal biopsy, nonspecific biopsy, or possibly diagnosis of granulomatous disease. Only one patient with cirrhosis had neither liver enlargement nor abnormal liver function. It is also apparent that liver function tests, like many other laboratory tests, provide useful information only if they are performed to answer pertinent questions.

In a review of 10,600 biopsies, Terry⁸ reported a mortality of 0.12% in patients subjected to liver biopsy and of major complications in 0.32%. Zamcheck and Klausenstock⁹ reported that deaths occurred mainly in patients with a hopeless prognosis. This would certainly seem to apply to one of the two deaths in the present investigation. These authors also stated that the risk of biopsy was increased in the presence of jaundice.

It is suggested that the high-

er mortality and morbidity encountered in this review may be due to the fact that biopsies were performed by a large number of the house staff, with resultant limitation of both clinical and technical expertise. A subsequent report will deal with the altered statistics subsequent to the institution of a policy requiring all liver biopsies to be performed by a Fellow in Gastroenterology.

Summary

The records of 200 patients undergoing percutaneous liver biopsy by the resident staff were examined. Fifty percent of biopsies were diagnostic, but the clinical diagnosis was altered by positive findings on biopsy in only 6%. Normal biopsy was obtained in 23% and nonspecific findings in 22%. No liver specimen was obtained in 4.5%. When liver enlargement was present 76% of biopsies were diagnostic.

An isolated abnormality of transaminase, bilirubin, or BSP was associated with a diagnostic biopsy in 62% to 75%. The highest yield (82%) was obtained when three chemistries were abnormal. Histological evidence of hepatitis was found only in the presence of abnormal liver chemistries. Cancer was demonstrated only when both hepatomegaly and abnormal chemistries were present. The pathological diagnosis most often established by biopsy when both liver size and function were normal was granulomatous disease.

Acknowledgment is made to Gerontology Research Center, NICHD, for use of facilities provided under its guest scientist program.

Information and reprint requests to Dr Schuster at Baltimore City Hospitals, 4940 Eastern Ave, Baltimore Md 21224.

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Health Care

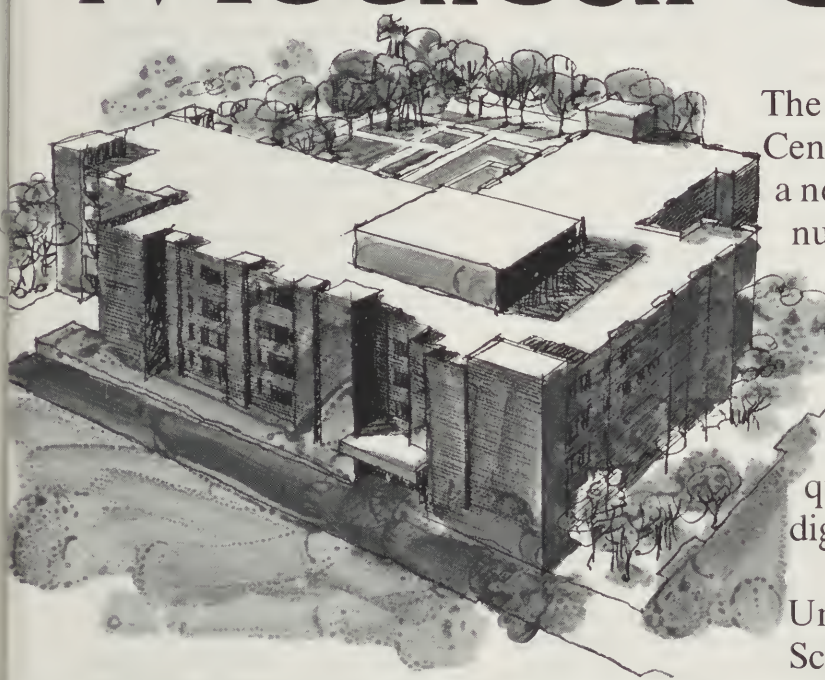
Most Americans are satisfied with the nation's health care system and do not see current problems as a crisis warranting "radical overhaul of existing institutions." They also place "greater confidence and trust in organizations of doctors such as the AMA than in any other potential contributor to the development of new federal health legislation."

Those findings are based on surveys reported in a new book, *U.S. Health Care: What's Wrong and What's Right*, by Stephen Strickland, Universe Books, NY. The need for "some basic changes" in the health care system was expressed by 61% of the public and by 66% of the physicians surveyed. But, as Strickland notes, the public does not want fundamental values violated.

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REYE'S SYNDROME IN BALTIMORE

A Review of 16 Cases

STUART H WALKER MD
Professor of Pediatrics
University of Maryland
School of Medicine

CHARLES J SCHLEUPNER MS (Hyg) MD
Intern
Salt Lake City Hospital

From the Department of Pediatrics, Mercy Hospital, 301 St Paul Place, Baltimore, Md 21202.

Information and reprint requests to Dr Walker at Mercy Hospital.

Materials, Methods

The intent of the survey reported herein was to discover all cases of Reye's syndrome which had occurred in Baltimore since the disease was delineated. All hospitals providing pediatric care in the metropolitan area were contacted. Sixteen cases occurring between June 1964 and March 1971 were discovered at Greater Baltimore Medical Center, University of Maryland Hospital, Johns Hopkins Hospital, St Agnes Hospital, St Joseph Hospital, Sinai Hospital, and Union Memorial Hospital.

The heads of the departments of pediatrics and the medical records librarians of the hospitals were asked to supply the names and chart numbers of patients who, in the recent past, had suffered acute nontraumatic encephalopathy. Forty charts were reviewed. Criteria for inclusion in this report as a case of Reye's syndrome were the following:

- 1) Rapid deterioration
- 2) Stupor and/or coma
- 3) Respiratory irregularity or tachypnea (rate greater than 40/minute)
- 4) Abnormality of serum glucose (60-110 mg/100

ml considered as normal range) and/or CSF glucose (40-75 mg/100 ml considered as normal range)

- 5) An elevated SGOT (greater than 50 Karmen units)

Selected cases were grouped according to a trimonthly date of onset during any calendar year, ie, January through March, April through June, etc. The age (mean, median and range), race, and sex were tabulated for both survivors and fatalities. The presence of an infectious contact, defined as a positive history of an upper respiratory infection (URI) and/or varicella within the family or social contacts of a patient, was noted.

The socioeconomic level of each patient was defined as **lower** when adverse living conditions were noted (eg, multiple families within one household, home in ghetto area, etc), and/or when State Medical Assistance was utilized, as **middle** if qualifying as neither lower nor upper, and as **upper** if the parental income came from a professional occupation, high executive position, etc. The patient's geographic localization was defined as **urban** if the home address was within Baltimore City limits or **suburban** if outside those limits.

The most ominous clinical sign noted when the patient was first seen by medical per-

sonnel was considered to be the chief complaint.

Encephalopathy and fatty degeneration of the viscera was described as a disease entity by Reye et al in 1963.¹ The simultaneous occurrence of similar signs and symptoms had been described previously by others,² including Brain et al in 1929.³ The syndrome described by Reye et al¹ consisted of a prodromal period of malaise with cough, sore throat, earache, and/or rhinorrhea followed usually within one to three days by abrupt clinical deterioration—persistent severe vomiting, stupor, progressing to coma, and, frequently, convulsions.

The upper respiratory symptoms were often separated from the acute deterioration by a short period of apparent recovery. Respiratory irregularities and hepatomegaly were frequent associated findings. Laboratory abnormalities included alterations in cerebrospinal fluid or blood glucose, azotemia, abnormal liver function tests (SGOT, SGPT, prothrombin time), and neutrophilic leukocytosis.

Seventeen of 21 cases reported by Reye died, all within several days after hospitalization. Gross pathological changes included cerebral swelling, hepatic enlargement, widened renal cortices, and cardiac dilatation.

Microscopic findings included sudanophilic granules

within the cerebral neurones and capillary endothelial cells, and fatty changes in the liver and in the renal tubules. The correlation of this clinical state and these pathological findings have been confirmed by others.^{4,5,6} The probable importance of liver dysfunction in the pathogenesis of the syndrome has recently been emphasized.^{7,8,9}

Experience with the syndrome in Baltimore has differed in many respects from that reported elsewhere.^{5,9,10} It therefore seems appropriate to report a survey of 16 patients treated in Baltimore hospitals whose disease was particularly severe.

These included stupor and/or coma, seizure of any type, vomiting, and respiratory distress (rate greater than 40 per minute). Clinical signs noted during the patient's illness included the above plus preceding infection within two weeks of admission, hepatomegaly as determined by physical examination at any time during the hospital course, fever greater than 100°F, and papilledema.

Laboratory values tabulated for each patient in the study included the total white blood cell count (WBC), the serum electrolytes (sodium, potassium, bicarbonate), total serum bilirubin, serum glutamic-oxaloacetic transaminase (SGOT), serum ammonia, serum and cerebrospinal fluid (CSF) glucose, and blood urea nitrogen. Means and ranges of values for all recorded laboratory measure-

ments in each patient were determined. Values determined after recovery in the survivors were excluded.

The use of various therapeutic agents was tabulated for both survivors and fatal cases. Those medications considered were osmotic diuretics, steroids, antibiotics, and anti-convulsants.

Also compared for survivors and fatalities were the duration of illness until hospitalization (illness defined as onset of behavioral change, vomiting, or respiratory distress, whichever occurred initially) and the duration of hospitalization (until discharge or death). Exposure within one week of the onset of Reye's symptomatology to DPT vaccine injection and/or various medications (aspirin, phenothiazine, or antihistamine, antiemetics, antibiotics, pseudoephedrine, Tigan) was tabulated for each group.

Microbiological isolates (viral and/or bacterial) from CSF, feces, and/or postmortem material were noted, as were serum antibody determinations associated with various viral infections including Herpes simplex, varicella, mumps, rubeola, LCM, influenza "A" and "B," ECHO, Coxsackie, adenovirus, and eastern and western equine encephalitis. The death certificate designation for each case was recorded, as were the frequent postmortem findings among the autopsied cases.

Results

Of the 40 medical records

reviewed, 16 described disease states which fulfilled the criteria for inclusion as cases of Reye's syndrome. Of the 16 cases, two survived, and 14 were fatal.

The trimonthly incidence of the cases over the 82-month period covered by the study is shown in Table 1. Ten of 16 cases (62.5%) occurred during the first three months of the year and an additional four cases occurred during the last three months. Thus 87.5% occurred during the fall and winter months. None occurred during the summer. No case occurred within 30 days of another.

The age distribution of the 16 cases is given in Table 2. No pediatric age group was spared: 25% were less than one year of age, 31% older than ten years of age. One survivor was three months of age, the other seven years. The racial and sex distribution (Table 3) reveals a predominance of white males among the 16 cases. There were no age, race, or sex-related differences between survivors and fatalities.

Fifty-four percent of 13 cases (whose records were deemed adequate) had a history of recent contact with an acute infection, upper respiratory in six, varicella in two.

The socioeconomic level and geographic localization of the 16 cases studied is presented in Table 4. Most cases (81%) came from middle-income families who lived in a suburban or rural locale (69%). Survivors and fatal-

Table 1: Timonthly Incidence¹ of 16 Cases of Reye's Syndrome Admitted to Baltimore Hospitals Between June 1964 and March 1971

Subgroup	Jan-March	April-June	July-Sept	Oct-Dec	Total Cases
Survivors	1 (50%)	0	0	1 (50%)	2 (12.5%)
Fatalities	9 (64%)	2 (14%)	0	3 (21%)	14 (88%)
Total Cases	10 (62.5%)	2 (12.5%)	0	4 (25%)	16 (100%)

1. Expressed as number and percent of cases within each subgroup per each three-month period.

Table 2: Age Distribution¹ of 16 Cases Reye's Syndrome Compared to Race and Sex

Age groupings (in years)	Cases per group	Race		Sex	
		White	Black	Male	Female
Less than 1	4 (25%)	3 (19%)	1 (6%)	1 (6%)	3 (19%)
1 to 4 11/12	2 (12.5%)	3 (12.5%)	0	2 (12.5%)	0
5 to 9 11/12	5 (31%)	5 (31%)	0	4 (25%)	1 (6%)
10 to 14 11/12	4 (25%)	4 (25%)	0	4 (25%)	0
15 to 16	1 (6%)	1 (6%)	0	0	1 (6%)

1. Given as number of cases per grouping and percent of total cases.

Table 3: Racial and Sex Distribution¹ of 16 Cases of Reye's Syndrome

Subgroup	Race		Sex	
	White	Black	Male	Female
Survivors	2 (100%)	0	2 (100%)	0
Fatalities	13 (93%)	1 (7%)	9 (64%)	5 (36%)
Total Cases	15 (94%)	1 (6%)	11 (69%)	5 (31%)

1. Expressed as number and percent of cases within each subgroup.

Table 4: Comparison¹ of Socioeconomic Levels & Geographic Localizations of 16 Cases of Reye's Syndrome

Subgroup	# of cases in subgroup	Socioeconomic level			Geographic local	
		Lower	Middle	Upper	Urban	Suburban, Rural
Survivors	2	0	2 (100%)	0	0	2 (100%)
Fatalities	14	2 (14%)	11 (79%)	1 (7%)	5 (36%)	9 (64%)
Total cases	16	2 (12.5%)	13 (81%)	1 (6%)	5 (31%)	11 (69%)

1. Given as numbers and percent of cases within each subgroup.

Table 5: Frequency¹ of Exposure to Various Medications Among 16 Cases of Reye's Syndrome

Subgroup	# of cases within subgroup	Acetyl- salicylic acid	Phenothiazine antiemetics ²	Antihistamine antiemetics ³	Antibiotics ⁴
Survivors	2	0/2	0/2	1/2 (50%)	0/2
Fatalities	14	9/14 (64%)	4/14 (25%)	2/14 (29%)	4/14 (25%)
Total cases	16	9/16 (56%)	4/16 (25%)	3/16 (19%)	4/14 (29%)

1. Expressed as fraction and percent of cases within each subgroup.

2. Including Thorazine, Compazine.

3. Including Benadryl, Triprolidine.

4. Including, Omnipen, penicillin G, Aureomycin.

Table 6: Frequency¹ of Types of Chief Complaints Among 16 Cases of Reye's Syndrome

Subgroup	# cases within subgroup	Stupor or coma	Seizure	Behavioral change	Vomiting	Respiratory distress
Survivors	2	0	0	2/2 (100%)	0	0
Fatalities	14	5/14 (36%)	5/14 (36%)	2/14 (14%)	1/14 (7%)	1/14 (7%)
Total cases	16	5/16 (31%)	5/16 (31%)	4/16 (25%)	1/16 (6%)	1/16 (6%)

1. Given as fraction and percent of cases within each subgroup.

ities showed the same distribution.

The duration of illness prior to hospitalization was slightly longer for fatal cases (1.7-day mean v 1-day mean for survivors). Examination of the frequency of exposure

to various medications (Table 5) reveals a high incidence of prior aspirin ingestion (nine cases, all of which were fatal). Other medications were infrequently involved. Serum salicylate levels (when obtained) were not in the

toxic range. No other toxins were detected by screening tests of urine.

Seizure and stupor or coma were the most frequent types of chief complaint (Table 6), characteristic of cases which were fatal. The two survivors

Table 7: Frequency¹ of Occurrence of Various Clinical Signs Among 16 Cases of Reye's Syndrome

Subgroup	# cases within subgroup	Seizures	Fever	Vomiting	Hepato-megaly	Papille-dema ²	Preceding Infection URI	Varicella
Survivors	2	2/2(100%)	2/2(100%)	2/2(100%)	2/2(100%)	1/1(100%)	0/2	1/2(50%)
Fatalities	14	14/14 (100%)	13/14 (93%)	12/14 (86%)	6/14 (43%)	6/14 (43%)	13/14 (95%)	0/14
Total cases	16	16/16 (100%)	15/16 (94%)	14/16 (88%)	8/16 (50%)	7/15 (47%)	13/16 (81%)	1/16 (6%)

1. Given as fraction and percent of patients within subgroup.

2. Only evaluated in 15 of the 16 cases (omitted for 1 of surviving patients); thus total percentage is based on 15 cases only.

Table 8: Variation of Laboratory Values¹ for 16 Cases of Reye's Syndrome

Laboratory Measurement	Patient Subgroup			
	Surviving Cases		Fatal Cases	
	Mean	Range	Mean	Range
WBC (cells/mm ³)	21,700	9,000-29,300	18,400	3,100-49,900
Serum Na (mEq/l)	142	134-153	143	97-160
Serum K (mEq/l)	5.1	4.1-6.2	5.1	3.0-9.8
Serum HCO ₃ (mEq/l)	16.3	9.6-20.8	19.3	5.0-29.0
Total Serum Bilirubin (mg/100 ml) ²	0.95	0.3-1.8	2.0	0.2-4.4
SGOT (Karmen units/ml) ³	370	12-1000	681	76-2700
Serum ammonia (mg/100 ml) ⁴	179	57-300	191	141-350
Serum glucose (mg/100 ml)	99	8-148	136	16-350
CSF glucose (mg/100 ml) ⁵	56	23-107	89	20-138
BUN (mg/100 ml)	24	6-53	40	8-169

1. Where multiple values existed for a single patient, their average was obtained and this value was employed in the computation of the mean for the subgroup; Individual laboratory values of each case were employed in determining the range for the subgroup.

2. Determined in 7 fatal cases and in both survivors.

3. Determined in 13 fatal cases and both survivors.

4. Determined in 3 fatal cases and 1 survivor.

5. Determined in 12 fatal cases and both survivors.

Table 9: Frequency of Viral Isolates Among 16 Cases of Reye's Syndrome

Subgroup	Fraction Cultured ¹	Fraction positive ²
Survivors	2/2 (100%)	2/2 (100%)
Fatalities	5/14 (36%)	1/14 (7%)
Total Cases	7/16 (44%)	3/16 (19%)

1. Expressed as fraction and percent of cases within each subgroup.

2. Expressed as fraction and percent of cases within each subgroup which were positive when tested.

presented with neither seizures, alterations in consciousness, vomiting, nor respiratory distress. Their initial combative behavior progressed to seizures and coma during hospitalization, however, and vomiting was prominent. Table 7 indicates the high frequency of seizures, fever, vomiting, and preceding URI (100%, 94%, 88%, and 81%, respectively). Hepatomegaly and papilledema were noted in about half of the cases (50% and 47%, respectively). One patient from whom varicella-zoster virus was isolated demonstrated typical varicella lesions at the time hospitalization. None of the patients was noted to be jaundiced.

Means and ranges of various laboratory values for surviving and fatal cases are presented in Table 8. Differences between most determinations for survivors and fatalities seem insignificant. However, serum and CSF glucose concentrations are higher (ie, means and ranges of values) among fatal cases. The ranges of serum sodium and potassium concentrations in the fatal cases indicate frequent abnormalities in both directions which are probably consequent to the disease and its management rather than causative of it. Total serum bilirubin, serum oxaloacetic transaminase (SGOT), and blood urea nitrogen (BUN) are slightly higher, probably indicating a greater degree of hepatic and renal injury in the fatal cases. Two patients, both of whom died, demonstrated slightly elevated CSF cell counts, 6 and 14 mononuclear cells per cubic millimeter. Three patients, one a survivor, demonstrated CSF protein concentrations greater than 60 mg/100 ml. Qualitative proteinuria (greater than 1+) was noted in approxi-

mately half the patients, survivors and fatalities.

There was no evidence that the use of a particular agent contributed to survival. Most of the 16 cases were treated with steroids (including dexamethazone, prednisone and Solu-Cortef) and antibiotics (including neomycin, ampicillin, chloramphenicol, methacillin, penicillin, kanamycin, and oxacillin), nine were treated with anticonvulsants, and five with an osmotic diuretic. Viral agents were isolated from three patients, including both survivors (Table 9). Confirmatory serological evidence of infection (complement fixation titre 1:128 in convalescent serum) was found in one survivor in whom varicella-zoster virus was isolated from a typical varicella vesicle. Polio virus type I was isolated from the stools of the other survivor. This was presumably a vaccine virus as the patient had recently received Polio Type I oral vaccine. Influenza B virus was isolated from the lung at autopsy in one case which occurred during a local epidemic of influenza B virus infection.

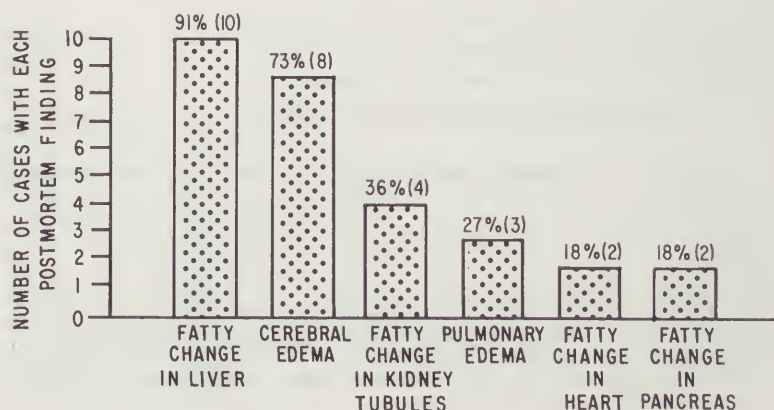
Fig 1 indicates the frequency of post-mortem findings among the eleven autopsied cases. Fatty liver and cerebral swelling were the

most common findings (ten and eight cases, respectively). Fatty change in the renal tubules was detected in four cases. A similar accumulation of fat in the myocardium and pancreas were found in two cases and pulmonary edema was found in three.

Discussion

The high incidence of Reye's syndrome in the elementary school years suggests a relationship to exposure to communicable disease. The high incidence in winter suggests a relationship to exposure to acute respiratory disease. The clinical association with nonspecific upper respiratory infection confirms this suggestion and indicates that the relationship is probably with viral disease. A variety of viral agents were detected in patients with the syndrome.^{11,12} The association with Influenza B virus infection noted herein and by others⁶ supports the implication that this viral agent may precipitate Reye's syndrome. The isolation of the varicella-zoster virus in one of our patients, and the clinical association with varicella noted by others,^{2,6,7} suggests that this agent may also precipitate Reye's syndrome.

As Reye's syndrome is clearly an infrequent accompaniment of viral infection, it



seems likely that its occurrence represents the distinctive response of certain predisposed hosts. In recent years, in Baltimore at least, these hosts were white, elementary school children from advantaged homes in the suburbs. The majority of the population of Baltimore City is black, yet but one black child was recognized to have Reye's syndrome in this city between 1964 and 1971. The preponderance of high socioeconomic and suburban origin of the affected children may be merely a different expression of their being white. However, one difference between such children and the apparently protected black children of similar age in the inner city is the greater exposure of the latter to viral respiratory infection in their preschool years. Perhaps poorer sanitation and earlier acquisition of active immunity to viral infection provides some protection to the black child as he enters the age period of susceptibility to Reye's syndrome.

The 16 cases reviewed differed from others observed in the United States^{6,9,10} chiefly in their greater severity and greater mortality. They closely resembled cases described by Reye⁴ in Australia. All had convulsive seizures, all became comatose, and 14 of the 16 died. The mean duration of illness in the fatal cases was 4.9 days, with a range between one and six days. In most instances the initial course of the disease was fulminant; the mean duration of central nervous system symptoms was 1.6 days. It seems unlikely that delay in diagnosis accounted for the increased severity noted. It seems equally unlikely, however, that the supportive therapy provided modified the course of the disease. One survivor received

mannitol and steroids while the other did not. Neither exchange transfusion nor dialysis was attempted in any of the patients. It is possible that the ultimate severity and the mortality could have been modified by the more aggressive therapy suggested by Huttenlocher.⁹ Age was not obviously related to survival.

There were no significant differences between mean values of various laboratory determinations in survivors and in fatal cases. No correlation between hypoglycemia or hypoglycorrachia and increased mortality was evident. Indeed, hypoglycemia and hypoglycorrachia were observed infrequently. Elevated concentrations of glucose were more commonly noted than depressed concentrations. Inclusion in the review required a deviation from normal in one direction or the other. Hyperkalemia was occasionally noted in both survivors and fatal cases but did not have any prognostic significance. Leucocytosis was prominent in these patients, an association not previously emphasized. Significant cerebrospinal fluid pleocytosis should be considered inconsistent with the diagnosis of Reye's syndrome. It is obviously essential to distinguish an early bacterial meningitis which may produce a clinically identical state.

The pathological findings in these patients are consistent with those previously described. The widespread fatty change should be emphasized. The outcome of the disease may depend upon the degree of hepatic and cerebral injury, but many other organs are affected. The noxious factor, toxin or microbe, is widely disseminated to kidney, heart, and pancreas and interferes with cell function in these organs as well.

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HIPPOCRATES: MEDICAL GIANT IN THE SAGA OF MAN

MRS CHARLES H WILLIAMS

Mrs Charles H (Margaret) Williams is Past President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland; she is also a Past President of the Woman's Auxiliary to the Baltimore County Medical Association.

A complete list of the 33 references used with this article may be secured from the author at Eagle Hill Rd, Charles' Choice, Pasadena Md 21122. Information requests and comments should also be directed to her.

THE OATH OF HIPPOCRATES

I do solemnly swear . . . by that which I hold most sacred . . . That I will be loyal to the profession of medicine . . . and just and generous to its members . . . That I will lead my life . . . and practice my art . . . in uprightness and honor . . . That into whatsoever house I shall enter . . . it shall be for the good of the sick . . . to the utmost of my power . . . I hold myself aloof from wrong . . . from corruption . . . from the tempting of others to vice . . . That I will exercise my art . . . solely for the cure of my patients . . . and will give no drug . . . perform no operation . . . for a criminal purpose . . . even if solicited . . . far less suggest it . . . That whatsoever I shall see or hear . . . of the lives of men . . . which is not fitting to be spoken . . . I will keep inviolably secret . . . These things I do promise . . . and in proportion as I am faithful to this my oath . . . my happiness and good repute be ever mine . . . the opposite if I shall be forsworn.

Among historians, it is felt that the good left by Hippocrates to date is threefold: his writings (which include his oath), his elevation of medicine as an art, and his relationship to his patients.¹

Hippocrates II of Cos was born 460 BC on the Island of Cos. He was the second of seven sons born of a physician named Heracleids of the family of Acclepiadae. His mother was a midwife; through her line he traced his ancestry to Hercules. He was educated at Cos; his first teacher was his father. He left this land at an early age, probably for a wider sphere to exercise his talent after the death of his father. He received instruction also from Gorgias of Leontini and his brother Herodicus of Athens.²

Hippocrates lived in a period of geniuses. Never (before or since) have so many great minds appeared in the same space at the same time. His contemporaries were Pericles, Pheidias, Aristophanes, Socrates, and Plato. This was a time in history that radiated fantastic intellectual light.

Two sons were born of Hippocrates and both became physicians. Draco became physician to the wife of Alexander the Great, while Thessalus became physician to Archealaus, King of Macedonia. During their life, the principles of Hippocrates were preciously guarded and their writings bore the name of their father.³

Doctors representing the aristocracy among their profession were those whose families practiced for generations. Since Hippocrates' grandfather was also a physician, he was held in great regard. He accepted students on a fee basis. The

student was then adopted into the family of this physician and worked with him for a number of years. The students shared the rights and obligations of their teacher, assisting him with patients, with the surgery, keeping things in order, as well as listening to oral instructions, and taking notes. The students, as well as the slaves, were instructed in caring for the poor.

Hippocrates traveled extensively but practiced mainly in the island of Thasos and in various towns of Thessaly. Apparently unaware of his genius, he carried himself in a grave manner, did not covet money, and was lover of Greece.⁴

Hippocrates was a gifted writer. His writings are distinguished by their simplicity and force. The writings can be classed on a par with Homer, as Hippocrates was also a great Classical author of his own and of all time. He always had at his command the right word with precision of expressions being brief and dramatic like those of the best Greek writers.⁵

The oath of Hippocrates has been used by men in medicine since about 400 BC—some believe even beyond this time. Because of the tender regard Hippocrates had for his patients, credit has been given him for the authorship of this oath; but because he stressed such respect for "the ancients"⁶ it is felt that many of the ideas were those of physicians before him. The oath illustrated the conditions of medical practice and its aim was to win for the one who practiced it a good reputation. This remains true today.

Baas reports, "the most brilliant and external contributions of Hippocrates to medicine are the

maxims: 'Follow nature; The physician is a servant not a teacher of nature; The physician is a servant of art; Natures are the physicians of disease; The physician should benefit or at least not injure; Where is love for art, there is also love toward man' ".⁷

There are 53 writings which are felt to be Hippocratic. According to Renourd the following works seem to be authentic writings: *The Prognostics*, *The Aphorisms*, the first and third books *On Epidemics*, *The Regimen in Acute Diseases*, *On Airs, Waters and Places*, *On Articulation*, *Luxations and Fractures*, and the treatises on *Instruments and Reduction*.⁸ Books considered almost certainly genuine are *Ancient Medicine*, *Surgery*, *The Law*, *Fistulae*, *Ulcers*, *Hemorrhoids* and *On the Sacred Diseases*.⁹

Probably Hippocrates most famous book is *Air, Water and Situations upon Epidemical Diseases*, and upon *Prognostics*. The word prognosis in medicine is "genuinely Hippocratic" and means "the future."¹⁰ No other physician before him put so much emphasis on the prognosis of the patient.

Hippocrates thought a physician should consider the seasons of the year, and the effect, in an illness. He believed each season was not alike and was capable of producing different symptoms, and so affected the health of an individual. He also stressed the winds. He felt some winds were hot, others were cold, some were common to all countries, and some were peculiar to certain areas. He stressed the waters for drinking, also. He believed waters differed in taste and weight; whether it was rain or snow, spring or salt water should be considered. He believed when a man entered a city he should review the situation in respect to the Winds and the rising of the Sun.¹¹

Sigerist wrote: "*Epidemics* is a good example of medico-geographic raw materials, notes on weather conditions and diseases observed at that time".¹² It was his opinion that these writings are unique when examined today, not only for medical information but for literary documents as well.¹³ In 1794 the School of Medicine in Paris was required by the Director to give courses in *Hippocratic Medicine and Rare Cases*. By 1811 these courses were abolished as unnecessary since on survey it was found that 11 professors were teaching Hippocratic medicine.¹⁴ "Today" quoting Sigerist, "these writings are still exerting a profound influence on our life whether we are aware of it or not".¹⁵

Hippocrates famous precept, "Life is short, opportunity fleeting, judgment difficult, treatment easy, thought hard, but treatment after

thought is proper and profitable,"¹⁶ was as true then as it is now. He founded the bedside method for the study of the patient, as well as the meaning of "Clinician," as he spent hours upon hours observing a patient. He paid little attention to concepts not based on observation; but this was not exclusive to Hippocrates,¹⁷ as he used most of his knowledge based on tradition. He is, however, given credit for creation of prognostics, diagnostics, therapeutics, and symptomatology. He had no name for a disease as he kept it free from the perplexities of theory.¹⁸

Of the 42 cases written up by Hippocrates, almost the only records of its kind in the next 1700 years, 60% are reported as to have been fatal.¹⁹ "I have written this down deliberately," say Hippocrates, "believing it is valuable to learn of unsuccessful experiments and to know the causes of failure." (Cited by Osler in his lectures in New Haven 1921).²⁰ By doing this he developed the first scientific approach to the study of the patient and many of his findings still remain valid. This first-hand approach is the power behind all science.²¹

According to Moon, some of the ideas of Hippocratic medicine are:

- 1) The human body is animated by an innate heat, the evaporation of which causes death.
- 2) There are in the Body four primary Humors, namely Blood, Phlegm, Yellow Bile, and Black Bile. Disease is a result of derangement of this mixture.
- 3) In the absence of all knowledge of chemistry and such, coction was used to explain the changes of food coming from outside eventually appearing as bones, flesh, and blood (corresponds to modern chemical composition and decomposition).
- 4) The condition of health is a correct proportion between work and nutrition of a person considering his age, the seasons, and the climate.
- 5) Crisis is any rapid change in a disease whether cure or death.²²

Physicians during this time frequently waited until the crisis to start treatment. Hippocrates stressed treatment at the onset of the disease and to sustain treatment at the time of crisis. He even went so far as to eliminate foods during this period.

Diet played a most important part in the treatment of the illness by Hippocrates. He advocated complete abstinence of food if the patient was strong enough. During fevers he allowed much drink and withdrew nourishment. Although he had no stereotype system, he followed rigid dietary measures and discontinued all

treatment during crisis.²³ He regulated the diet and was the creator of dietetics for the sick. In his treatment, it was the foreground of all therapeutic activities. He used chiefly liquids in chronic illnesses and advocated strengthening regimes of milk cures. He stressed drinking pure spring water, "wine mixed with water occasionally to get a little tipsy but to control the passions."²⁴

The time of Hippocrates was an age of reason. He dissociated medicine from theurgy and philosophy, and brought together the knowledge of the Coan and Cnidian Schools into a systemic science. He contended that epilepsy was no more sacred than any other disease and had a natural cause. Scythian men were relatively sterile and this was taken as an ordinance of the Gods. Hippocrates gave as his explanation of this phenomenon as that which might be due to excessive riding.²⁵ Jaeger goes as far as to say "that the Greek ideal of culture was the ideal of health."²⁶ Health, then as well as now, became a cherished possession. Hippocrates obtained his greatest, more on the power to predict clinical happenings, than on his power to control them. He divided diseases into acute, chronic, endemic, and epidemic.

The only anatomy learned by the Greeks was that from dissection of animals, yet Hippocrates "was aware" according to Baas, "of the pericardium, two ventricles, and the thickness of the walls." He knew the auricles do not contract exactly when the ventricles do. He knew the liver was used in the preparation of blood and bile. He knew of the vena cava, duodenum, the mesentery, the seminal vesicles and the rectum.²⁷ Many of these views were lively discussions in the 17th century. His mind and senses were used as instruments and his high seriousness and deep respect for the patient were apparent.

His text on malarial fever was part of the information used up to 1840. It was written, "his remarks on phthisis, puerperal septicemia, epilepsy, epidemic parotitis, the quotidian, tertian, and quartan varieties of remittent fever"²⁸ with a few changes could be found in any medical text of today.

Without the knowledge of anatomy, he concluded while "bleeding" the upper part of the body, the arm, head, neck, and tongue were to be used. In bleeding the lower half, he recommended the feet were to be utilized. He taught when the urine was muddy, the body should be purged by shaking while with the intestines an enemata was to be used.²⁹

In hygienic matters, a patient was advised to observe what he tolerated well or badly, and then

to manage accordingly—stressing labor, rest, and sleep. Drugs were chiefly vegetable substances; however, some were from flesh of the horse, ass, or fox, and also asses' milk.

Narcotics were made from lettuce, mandragora, and lollium. As a prescription for a tickling throat, a patient would be given hyssop with vinegar and salt. A diurectic to flush the kidneys would be any of radishes, squill, asparagus, or garlic.³⁰

The Hellenistic physician remained essentially a surgeon rather than a clinician. The physician before Hippocrates did not group symptoms and did not interpret them. "To Hippocrates, medicine owes the art of clinical inspection for with his keen mind and no instruments of precision, he taught the basis of knowledge was going over and over, again and again, until the real values of the clinical picture stood out," says Garrison.³¹

Inglis notes: "Hippocrates has declined to propose cures, it could be argued out of a proper sense of his limitations as he did not know the cause of disease."³²

In conclusion, Baas remarked: "The undying importance of Hippocrates in medicine rest, first of all, not so much upon his enrichment of science with new material as upon the creation of a scientific medicine and art; upon the method and really great principles which he introduced for all time into science and especially into practice."³³

Hippocrates died 375 BC.

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John Galsworthy

FREDERICK J BALSAM MD
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rehabilitation medicine

THE ROLE OF SPORTS IN REHABILITATION OF THE HANDICAPPED

Part 2A: Functional Levels and Classification of Handicapped Athletes

NORMAN B ROSEN MD

Dr Rosen is Assistant Physician-in-Chief and Director of Rehabilitation Therapies for the Maryland Rehabilitation Center, 2301 Argonne Dr, Baltimore Md 21218. He is also Consultant in Rehabilitation Medicine at Baltimore's North Charles General Hospital and Kernan Hospital for Crippled Children. He is also Instructor in Rehabilitation Medicine at the University of Maryland Medical School.

Information and reprint requests to Dr Rosen.

"In the name of all competitors I promise that we will take part in these games, respecting and abiding by the rules which govern them, in the true spirit of friendship, unity, and sportsmanship for the glory of sport and the honor of our teams."

With these words, the 21st International Stoke Mandeville Games began in Heidelberg, Germany on Aug 2, 1972 as the flags of the 43 participating nations flew over the heads of the more than 1,000 competitors assembled on the field below, against a backdrop of one of Germany's most attractive settings in the Neckar valley. These were the largest wheelchair competitive events ever scheduled and as the 1,000 disabled men and women prepared to compete against each other for the next eight days, the months and years of frustration, despair, and personal loss were temporarily forgotten. A spirit of excitement and anticipation gripped the air and spread through the stadium as the athletes on the field, just as their more able-bodied colleagues were to do in Munich in a few weeks, started their Parade of Nations around the track.

The Wheelchair Paralympics (the Olympics for the Paraplegics) represented the culmination of long months and years of dedicated work and determined effort to overcome the physical handicaps that had suddenly transformed these men and women from able-bodied independent participating members of society to bewildered,

depressed, and helpless bodies, suddenly totally dependent on society for their very existence and for their most elementary and basic personal needs.

For the most part, these participants were patients with spinal cord injuries; indeed, the founding concept behind these games was that they were to serve as an outlet for physical, emotional, and social expression for the large number of paraplegic and quadriplegic patients that were filling the wards of the various rehabilitation hospitals and vocational training centers in the United States and abroad. It was hoped that, by demonstrating to the public the presence of the physical skills required to compete in athletic events, the potential vocational abilities of patients with these impairments would be appreciated. As the years progressed, however, patients with other types of disabilities were also allowed to compete. Thus, at the present time many types of wheelchair patients participate. Indeed, the 21st International Stoke Mandeville Games being hosted by the Federal Republic of Germany were called in German by the name of *Der Weltspiele Der Gelähmten*, or the *World Games for the Disabled*, which suggests the increased scope of the disabilities represented.

With the broadened spectrum of pathological conditions being exhibited by the participants of the Games, it was necessary to institute a system of functional classification in order to establish groups of comparable disability for each event. An international team of physicians carefully evaluates each participant to determine eligibility. Athletes are classified into various disability groups depending on the degree of involvement demonstrated at the time of the classification.

Levels of Function

Since the games were originally designed primarily for the spinal-cord injured, it is rewarding

**Table 1: Significant Levels of Function
(Upper Extremities and Trunk)**

C3:	Head and neck activity Trapezius (scapular adduction and rotation)
C4:	Diaphragm (primary muscle of inspiration) Scapular elevation
C5:	Rotator cuff (partial) Scapular stabilization Shoulder elevation Gleno-humeral abduction Elbow flexion and supination (fair)
C6:	Rotator cuff (full) Elbow flexion Forearm supination (strong) Forearm pronation (partial) Wrist extension (partial)
C7:	Shoulder depression (weak) Elbow extension (partial) Forearm pronation (strong) Finger extension Metacarpo-phalangeal flexion Thumb function (weak)
C8:	Thumb function (strong) Finger flexion Hand intrinsics (partial)
T1:	All hand intrinsics

to review the levels of function (Table 1) that are possible at each level of spinal cord injury. The classic description of these critical levels has been discussed by Long and Lawton quite thoroughly and their presentation of this material is highly recommended.

As a rule, patients with lesions at or above C5 or C6 do not have sufficient muscle function to participate in athletic activities. Lesions higher than this level may be inconsistent with life itself. Recalling that the innervation to the diaphragm is via the phrenic nerve which receives its innervation from C3 through C5, but primarily C4, it is readily seen that any lesion resulting from an injury at this level would leave the unfortunate victim a respiratory cripple or, at best, a patient with a severely compromised respiratory capacity. The able-bodied individual not only uses his diaphragm to breathe but also uses his accessory rib cage muscles to expand his rib cage for breathing when maximal air exchange is required. The intercostals, however, being innervated by the thoracic segments, are obviously below this level and are thus not capable of functioning.

The accessory rib cage muscles, the strap muscles of the neck, the platysma, and the sternocleidomastoids are innervated by the cervical segments higher than C4 or by the cranial nerves and are thus still capable of voluntary movement to assist in respiration if needed. However, these muscles, along with the trapezius, the high paraspinous muscles, and the cranial muscles are the only functioning muscle groups present

with lesions at this level. They can be used for some minimal activities of daily living but are insufficient to permit the patient to participate in significant athletic activity. Even using the newer techniques of myoelectric sensors and other similarly sophisticated amplifier equipment, it is unlikely that this group of patients would even be able to engage in physical activities of an involved nature or whether, indeed, this goal is a desirable one at this level of involvement. In order to perform even minimal activities, these patients require devices such as mouth sticks and head-and-neck controls to propel or activate externally powered equipment.

Thus, in summary, patients with lesions at C4 can be considered as requiring virtual total nursing and skilled care, with no potential or ability for self-care, and certainly none for athletic participation.

The C5 Quadriplegic

At the next level, C5, critical muscle groups are added, being innervated either completely or in part by this nerve root. The teres minor (C4-5), the supraspinatus (C4-6), and the infraspinatus (C4-6) give the patient at least partial use of the rotator cuff in addition to the upper cervical paraspinous muscles, the trapezius, and the sternocleidomastoids. The rhomboids (C5) aid the Levator scapulae (C3-5) in stabilizing the scapulae and elevating the shoulders; the deltoids (C5-6) allow adduction; the biceps (C5-C6) give the patient elbow flexion as well as supination. These latter three muscle groups are only partially innervated, however, since they also receive part of their innervation from the C6 level. The brachioradialis (C5-6) adds some additional elbow flexion and the supinator longus aids in forearm supination.

Thus, the patient with a lesion at the level of C5 has scapular adduction, glenohumeral abduction, internal and external rotation of the shoulder, and weak flexion and extension of the shoulder joint. In addition, there is good elbow flexion and supination. However, there is no active muscle power distal to the elbow. Also, the pectoralis (C5-T1), the latissimus dorsi (C6-C8), and the serratus anterior (C5-7) are either not present or, in the case of those few fibers that do receive innervation from C5, are not present in functional strength. Thus, the patient still may have trouble rolling over in bed or coming to a sitting position. Feeding is possible only by assistive hand devices. Wheelchair propulsion generally is difficult. Overhead slings and rocker-arms may increase the ability of the patient with this level of involvement to become more functional with regard to feeding himself, or accom-

plishing additional light self-care activities, such as shaving or brushing his teeth.

It is readily apparent that patients with such limited skills have only a minimal potential for athletic participation. However, they may and do compete in areas such as swimming, field events, stickbowling, and other table games, making free use of appliances and holders to achieve maximal results.

The C6 Patient

With addition of C6 innervation, significant functional musculature is added so that the patient can assist in many aspects of his own self-care and transfer activities. Again, as with the C5 involved patient, by using various orthotic devices, the patient with this lesion level can achieve a higher functional goal than his actual muscle level would otherwise permit. At the C6 level, the rotator cuff is fully innervated and the pectoralis major, the serratus, and the latissimus dorsi become partially but significantly innervated. Good upper extremity adduction thus appears as well. The pectoralis major in particular enables the patient to use his arms more effectively in the frontal plane without the need for overhead or rocker suspension systems. Elbow functions become more certain with addition of complete brachioradialis innervation, and wrist activity appears, primarily in extension (extensor carpi radialis C6-8). Although the flexor carpi radialis is also innervated in part, this is rarely of significant strength until the next level.

In functional activities, the C6 quadriplegic patient is able to substitute strong shoulder adduction for elbow extension and is able to thus "lock" his elbows during transfer activities. The patient has no active finger flexion or extension, but with the presence of the weak wrist extensor he can achieve a weak closure of the hand by taking advantage of the inherent elastic nature of the finger flexors, the so-called "tenodesis action" of the fingers. The C6 patient can propel his wheelchair using his existing musculature (elbow flexion and shoulder adduction) combined with the natural hand and thenar configuration to achieve this end.

The Significant C7 Level

In regard to the classification of the quadriplegic for participation in competitive sports, it is at the C7 level where the first major division can be made. Thus, an athlete who lacks even minimal use of these significant C7 muscles and who, therefore, is incapable of active elbow extension is classified IA, the most severely impaired. With the addition of the triceps graded in the Good range, the athlete is placed into the

Table 2: United States Classification System

- IA: Incomplete quadriplegic who has involvement of both hands, weakness of Triceps and a generalized weakness throughout the trunk and lower extremities
- IB: Incomplete quadriplegic who has some upper extremity involvement, less than IA but with trunk muscles and lower extremities similar to that of IA
- I: Complete spinal paraplegia originating at T9 or above or comparable disability where there is a total loss of muscular function originating at T9 or above
- II: Complete spinal paraplegia at T10 through L2 or comparable disability where there is a significant loss of muscular function of hips and thighs
- III: All other disabilities below L2

Table 3: International Classification System***

- IA: All cervicals without Triceps or very weak Triceps (to power of 3/5)*
- IB: Cervicals who have good Triceps and the 1st dorsal segment (power 4-5/5)*
- II: Below T1 to T5
- III: Below T5 to T10
- IV: Below T10 to L3
- V: Muscle function in lower extremities 10 to 29 points maximum**
- VI: Muscle function in lower extremities 30-50 (paraplegics) 30-45 (polios)**

* 3/5 meaning antigravity in strength, but unable to take any resistance

** See text for explanation of point system

*** System in use through 1972. Amended in 1972 relative to Classes IV, V, and VI (see Table 4).

IB classification (Tables 2 and 3). At this C7 level, in actuality, three very important functional improvements have been achieved: the Triceps (C7-T1) allow active elbow extension, the common finger extensors (C6-C8) become functional, and active thumb function appears. Furthermore, forearm pronation becomes strong and metacarpo-phalangeal flexion combined with proximal interphalangeal extension is added, thus providing a basis for improved hand function.

This is the level where the quadriplegic can be expected to achieve a significant degree of wheelchair independence. This goal is more likely if the quadriplegic patient is a male rather than a female. He can be trained to be completely independent in all transfer activities, toilet and self-care activities, and may even drive an automobile with the aid of hand controls. Hand skills are still not possible to any secure degree, although tendon transfers may take better advantage of the natural "tenodesis" positioning of the fingers, in addition to the weak finger extension and flexion present with this level lesion.

C8 and Below

With additional innervation to the thumb, the finger flexors, and the intrinsic muscles of the hands occurring at the next two levels, the hands become essentially functional. Thumb strength and dexterity appear with certainty at the C8 level, as does finger flexion and some intrinsic hand-muscle control. All the hand intrinsics become active at the T1 level, thus adding improved strength of grasp to the patient's functional activities.

From an overall functional standpoint, these quadriplegic patients are still quite handicapped since they do not have a normal vital capacity. This is due to the fact that the intercostals, which are innervated by the thoracic nerve roots, are still nonfunctioning. Only the diaphragm is capable of any degree of significant air exchange, and the quadriplegic patient still uses his accessory respiratory muscles to a great degree for the increased demands of athletic participation. As a result, a diminished vital capacity still hampers the quadriplegic athlete from participation in competitions which require endurance and vigorous oxygen exchange. In addition, trunk stability and balance are still precarious and must be reinforced with corsets or other such devices, which may further decrease the quadriplegic's vital capacity and respiratory reserve.

Even though the upper extremities are virtually completely innervated, good trunk control and body balance are essential in allowing the quadriplegic patient to use these extremities to their maximum advantage. Thus, even the very high thoracic paraplegic patient cannot gain maximum use of his upper extremities despite their being completely innervated, because of this lack of control of trunk muscle and strength. Only below the level of T5-T6 can the spinal injured patient rely on secure trunk control as a basis for strong upper extremity activity.

To be continued

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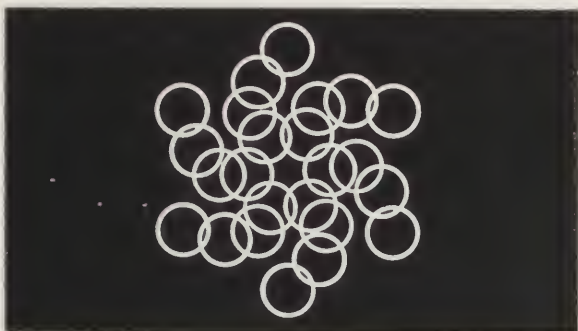
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TREATMENT OF ALCOHOLISM-PART III

Reprinted from "First Special Report to the US Congress on Alcohol and Health from the Secretary of Health Education and Welfare," December 1971, DHEW Publication (HSM) 72-9099.

Interpersonal

This system falls between the intrapsychic and the social small group systems, blending imperceptibly into each. Interpersonal therapy focuses on marital and family disorders and how they relate to the alcoholic person's marital partner or family member. It consists of give-and-take with important people in the patient's life today, rather than in the past, although those early love and hate experiences show up as a shadow over what the patient is doing now.

In caricature, for example, the wife of the alcoholic man is portrayed as a long-suffering, work-worn, red-eyed, self-sacrificing woman forever bewildered by her husband's alcoholic debauchery and irresponsibility. Scratching the surface a bit in interpersonal therapy, however, may reveal a rather steely woman, contemptuous of her husband and secretly pleased with her dominant role in the family. Surprisingly, this may not be her first marriage to an alcoholic man.

Further investigation might reveal some dynamics of her past relationships—the intrapsychic system. These would suggest she was acting out old shadows of disappointment in her father's failure to be strong and reliable. She neurotically recreates this scene in her present life by choosing alcoholic mates. If her unconscious choice of a mate does not quite meet the picture of her father—for example, if the spouse turned out to be insufficiently weak—she would subtly undercut and push her husband along the desired path to irresponsibility.

These dynamics can be mirrored when the nonalcoholic partner is the husband. Superior

and indifferent treatment of a wife can leave a woman with a growing loneliness and rage, finally culminating in her hidden alcoholism—that is, not hidden from her husband, but ignored by him and hidden by both of them from the world. How mismatched this intact and successful man seems to be with his now slovenly and brain-damaged wife. He must keep her from public view.

Yet, after loud proclamations that this drinking will no longer be tolerated, a nonalcoholic spouse may even be detected sympathetically slipping gin into the hospital for the alcoholic partner now under care for alcoholism. Or, take the example of the physician's wife struggling to avoid her destructive drinking which has become a public humiliation to her husband. Her husband asks her to buy champagne for their wedding anniversary because he forgot her problem with alcohol—a lapse of memory taking place after only a month of abstinence on her part!

In this marital situation, one prediction holds: The nonalcoholic spouse will unconsciously resist attempts of the alcoholic partner to recover. Subtle, or even not so subtle, means may be employed to undercut progress. If, despite these pressures, the alcoholic partner manages to recover, the effects may be devastating for the mental health of the spouse.

Attractive as these theoretical assumptions may be, life—fortunately—isn't that simple. Many wives and husbands of recovered alcoholic persons are delighted by the change; marriages are preserved, and great efforts are expended to encourage prolonged recovery. In other words, the variables are too many to allow accurate prediction.

A broader view holds that the nonalcoholic partner, even with many unresolved needs, is faced with an immediate reality: a chronically inebriated husband or wife. Assuming that the

causes lie more with the inebriate individual, to what advantage can this situation be used unconsciously by the nonalcoholic spouse? Faced with a painful reality, this spouse may seek some secondary gain to make up somewhat for the losses. Maybe, when intoxicated, the alcoholic spouse is more, or less, sexually directed . . . more, or less, generous . . . more, or less, communicative . . . or more, or less, intimate. Or, the wife may be faced with a great disappointment in her husband: She can no longer depend on him for support. She is forced to assume a greater and greater share of his responsibilities until finally, she is both mother and father in the house—a position she may find herself unconsciously enjoying.

Meanwhile, the alcoholic spouse may painfully be beginning to move toward recovery. The long-term results might be very much to the advantage of the spouse. For the short run, however, she may not be so willing to relinquish the secondary gains. Her husband demands to take back his man-of-the-house responsibilities. But can she be sure? Will this be just another brief attempt on his part, to be followed by another, even more painful disappointment? She hesitates, holds on to the reins, and gives only half-hearted support to his efforts. He wants back now; she isn't sure. He feels rebuffed and hurt and may go back to drinking. This sequence may be repeated several times.

TREATMENT. Because so many variables are involved in the differing constellations of marriages, the tendency is growing to treat the couple rather than just the alcoholic partner. An immediate resistance that has to be resolved is the belief of the nondrinking spouse that he or she isn't really in need of help but is coming to help the other. A first attack on this resistance is to point out that it is the marriage which is the patient; the alcoholism of one partner is merely the symptom of a sick marriage. Before long,

the complementary pathology of the nonalcoholic spouse is usually in full bloom, ready for therapeutic attention.

This approach may be widened to include other or all members of the immediate family. What role do children play in perpetuating a parental drinking pattern? A disdainful, "Is Dad drunk again?" could be a startling confrontation leading toward greater motivation to become well. Unfortunately, the question is more likely to be received with shame and resentment, both for good reasons "to really tie one on." The son's loss of self-respect as he sees his identification model crumbling may require painstaking rebuilding, which may be facilitated if he can participate with his father in the therapeutic reconstruction of the self-esteem of the entire family.

Sometimes the significant other, possibly the addict, needs to be identified and, if possible, brought into the picture. This could be Mom, Dad, or the mistress who finds her lover more responsive when he is drunk. These significant others are more difficult to bring into a therapeutic situation than a spouse. If the addict cannot be involved and persists in his or her role, the alcoholic patient may have to be helped to make a clean break for self-survival.

Offshoot organizations of Alcoholics Anonymous have been effective in this area of involving family members and helping them. Al-Anon, an organization for spouses of alcoholic patients, is available whether or not the alcoholic partner is in Alcoholics Anonymous or part of some other rehabilitation procedure. The great value derived from such an organization is to learn that one is not alone in this predicament and to take advantage of other spouses' trial-and-error attempts at better adjustment. Hopefully, greater understanding by the spouse may lead to ways to help the alcoholic partner toward treatment. Al-Ateen is a parallel organization for the teen-

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age children of an alcoholic parent; Al-Atots is for still younger children.

Social

Small Group

Not only do all of us have intrapsychic and intimate interpersonal experiences, but we also live in small social groups such as friends, acquaintances, clubs, neighbors, and interest groups that extend outside our families. Such contacts play a major role in maintaining identification roles and self-esteem, and in offering opportunities for controlled and healthy release of impulses. Unfortunately, the slow progression to alcoholism usually results in a loss of such contacts. Friends cease to be; old drinking buddies can't and don't wish to keep pace; neighbors are disdainful. The alcoholic person, already struggling with his waning sense of personal worth, progressively becomes alienated and lonely. He may project responsibility upon others for his social rejection. Within himself, however, he is only too aware of where the responsibility lies, thus confirming the worst of his already low self-appraisal.

TREATMENT. The prime example today of treatment provided within small group settings that take these factors into account is Alcoholics Anonymous, the major influence for the 30-odd years in gaining acceptance of the disease concept of alcoholism. The aim of Alcoholics Anonymous members is to help each other maintain their sobriety, and to share their recovery experience freely with anyone who may have an alcohol-related problem. The Alcoholics Anonymous program basically consists of "Twelve Suggested Steps" designed for personal recovery from alcoholism. Several hundred thousand alcoholic people have achieved sobriety in this way, but members recognize that their program is not always effective with all alcoholic individuals, and that some persons may require professional counseling or treatment.

Alcoholics Anonymous is concerned solely with the personal recovery and continued sobriety of individuals who turn to this fellowship for help. The organization itself engages in no research, no medical or psychiatric treatment, nor endorsement of any causes, although members often participate in such activities as individuals. Organizationally, Alcoholics Anonymous policy is one of "cooperation but nonaffiliation" with other organizations concerned with the problems of alcoholism. Alcoholics Anonymous is self-supporting through its own groups and members; contributions from all outside sources are declined. Members preserve personal anonymity



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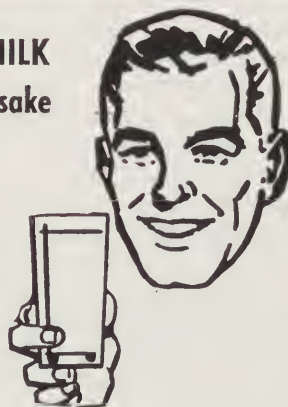
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To some, Alcoholics Anonymous has at times appeared defensive about the roles of professional groups in the field of alcoholism. These fears have largely disappeared as Alcoholics Anonymous members and the professions have come to know one another better. Mutual appreciation, cooperation, and understanding have emerged as a result of better communication between Alcoholics Anonymous and other groups in the field of alcoholism.

Alcoholics Anonymous keeps no membership records and provides no hard statistics. Thus, it is sometimes difficult to verify or explain its success in scientific terms. Nevertheless, it is easy to see why Alcoholics Anonymous should and does work so often. The fellowship seems ideally suited for the guilt-ridden and lonely person lying beneath the facade of good nature assumed by many alcoholic individuals before coming into Alcoholics Anonymous. This is not surprising, as Alcoholics Anonymous was developed by people who had experienced similar feelings.

Founded in 1935 by two hopeless alcoholic persons—a stockbroker and a surgeon—Alcoholics Anonymous has proved that hundreds of thousands of people can and do recover from alcoholism, and go on to become productive citizens. While Alcoholics Anonymous has no formal religious dogma, most Alcoholics Anonymous members rely on a spiritual approach—a Higher Power greater than themselves. For some, this reliance may well be the most important factor in their recovery. The “Big Book” of Alcoholics Anonymous is well worth reading. Many alcoholic persons, however, are not able to take the first step of Alcoholics Anonymous: “We admitted we were powerless over alcohol—that our lives had become unmanageable.” They need other forms of therapy before they can be motivated to accept the Alcoholics Anonymous program.

The person who does stay with the program also relies on the help of other alcoholic individuals as he sets out on a course of making amends for previous wrongs. He turns to helping others (Twelfth Stepping) not only for the sake of others (the professional viewpoint), but for his own continued personal sobriety. All of this activity occurs in a fellowship with others like himself who are in the process of recovering; in this fellowship, he is unconditionally accepted as a peer.

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coholic persons is represented by the halfway house, which has been developed to fill the serious gap that has arisen between hospital and outpatient services. The middle-class patient, for example, usually returns to or continues with his family. Many alcoholic persons, however, have lost old attachments. After detoxification and with good motivation toward rehabilitation, they unhappily run into the demoralizing situation where no one wants them and they have no place to go.

Originally instituted for various types of emotional disorders, the halfway house has probably performed its greatest service for the alcoholic patient. Generally, this patient can look back to a better experience of integration than, for example, the person with a long history of schizophrenia, and has greater potential to return to at least his former level of functioning. The alcoholic individual on the road to recovery may remain in a halfway house from several weeks to several months. Here he has an opportunity to continue confrontation group therapy, obtain proper nutrition, and take a breathing spell while he job-hunts or undertakes a vocational rehabilitation program. At the halfway house he has a built-in group of acquaintances, and is encouraged to extend his social circle. Very often, the halfway house has a strong Alcoholics Anonymous or spiritual orientation that provides him with vital support. Perhaps one of the greatest values of a halfway house is that it offers a "dry island" to which the recovered alcoholic person may retreat. Here in association with others to whom he relates, he temporarily insulates himself from community, family stresses, and drinking stimuli during his hours away from work.

Halfway houses may be part of a public network of rehabilitation services, or operated by nonprofit voluntary groups. Unfortunately, halfway houses are in short supply. This is especially true for women, for society often forgets that

women also have alcohol-related problems.

A day hospital falls between a halfway house and a hospital. The halfway house is for the person with no place to go, but who doesn't need a hospital. The day hospital is for the person who does have a place to go, is not quite ready to go there yet, but doesn't need full-time care.

In the day hospital, the alcoholic patient continues with group therapy, engages in resocialization, participates in vocational rehabilitation programs, and gradually increases his community contacts. He returns home nights and weekends, gradually decreasing the proportion of time he spends in the day hospital.

The night hospital or weekend hospital is a reverse variation on this theme. Perhaps the individual can return to a job which presents few stresses for him, yet needs time before he can return to where his real stresses lie—in his marriage and family.

A major roadblock to greater use of halfway houses, and day or other partial hospitalization techniques, is the failure of health insurance to realize that these approaches are less expensive alternatives to full-time hospital care. Hopefully, this penny-wise, pound-foolish attitude will be changed.

Large Group

The estimated nine million people in our midst with alcohol-related problems undoubtedly have a major impact on such large social groups as industry, the military, and our driving, flying, and boating populations. This is especially relevant when we consider the lack of realism in such traditionally held viewpoints as, "Alcoholics are bums so they don't hold jobs in our business or factory"; or, "Alcoholics are too poor to own automobiles, and those who do are too foxy to drive after drinking."

The fact that less than 5% of people with alcohol-related problems are on skid row makes it obvious that most alcoholics individuals are in

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the work force. And most of them, like most of us, do own automobiles and do drive.

TREATMENT. Within the work world, rehabilitation programs have several essential elements: a) case-finding, b) confrontation, c) motivation, and d) follow-up. A relatively easy person to identify is the individual whose job performance shows increasing impairment due to a behavioral problem which expresses itself through such symptoms as recurrent absenteeism, vague physical complaints, poor on-the-job interpersonal relationships, and decreasing efficiency. The issue is not so much the education of supervisors in early casefinding (they have a pretty good idea of who is in trouble), as it is in their companies establishing policies and procedures that allow them to take corrective action. It should be noted that the criterion for company action is the employee's job performance and not his use of alcohol. Similarly, the only criterion of successful response is improved job performance.

When impaired job performance indicates alcohol abuse or alcoholism may be involved, a company with an alcoholism program refers the individual to medical or personnel counseling services. These services may be an integral part of the company, or they may be community-based services that are used by the company under contract or other agreements. Conceptually, the assistance offered to the employee in this instance does not differ from that offered in cases of job impairment due to other disease-related conditions.

As in many other health and welfare plans, labor and management agreement is essential to the development of industrial alcoholism programs. There are several accepted procedures for implementing such programs. In general, an employee is offered and urged to accept a designated health service for diagnosis of a condition that may possibly be affecting his work. Such a health service identifies the nature of the problem and recommends an appropriate treatment course. In the case of alcoholism, this recommendation may be referred to a specified alcoholism clinic, a psychiatrist, Alcoholics Anonymous, or other appropriate caregiver. During this confrontation, the employee is given a clear choice of either improving his job performance or facing administrative disciplinary procedures. The offer to assist him is expressed firmly, but it must be accepted voluntarily. If treatment is accepted, the worker must show a reasonable effort to pursue treatment, and his work performance must also show improvement. If his performance continues impaired and he manifests little concern in obtaining treatment, the normal admin-

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istrative procedures based on deteriorating work performance take their course. If sincere treatment effort fails to improve his work, then the issue of disability retirement may have to be resolved. In cases where performance improves although no treatment is undertaken, no company action is warranted beyond monitoring the level of work to ensure that the problem does not repeat itself.

Early identification of the alcoholic employee is essential. A program at one company has already resulted in a 63% reduction in absenteeism; at another company, substantial rehabilitation has been achieved in 65% of the workers diagnosed as needing treatment for alcoholism. In both companies, early identification was stressed.

The cost of industry alcoholism programs is negligible compared to the cost of no program. The alcoholic worker, for example, is likely to be an older and more experienced employee. Studies in one large company showed that two thirds of employees identified as alcoholic persons had from five to 15 years of service. In another company, such employees averaged 22 years of service. Losing such workers is expensive; so is the cost of continued job impairment. But since these employees have much to lose in terms of seniority, the leverage for constructive on-the-job intervention is great.

When it comes to coping with alcohol-related traffic accidents, one form of positive intervention being tried out in many communities is therapy offered as an alternative to punishment, to the person arrested for driving when intoxicated. A full range of community services is being utilized, just as for the worker who is offered treatment instead of immediate job dismissal. Considering all the previously mentioned complexities of therapy, one standard and rigidly applied program is not likely to be successful. The US Department of Transportation is now funding pilot projects to discover what orientation might be effective. Traditional techniques of jail, fine, and license revocation have not been successful. Neither have the well-intentioned but naive attempts to alter this situation by a few lectures on the evils of "Demon Rum." Though they may act as if they didn't know the facts, the bulk of the students are all too knowledgeable about the effects of alcohol, but they are caught up in an addictive illness.

Society

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an uncertain proportion wonders whether drinking may be morally evil. For many, even social drinking requires a defiant pullaway from old family attitudes of abstinence. On the other hand, we have groups for which controlled drinking is the norm, but some may be undergoing changes from traditional customs toward uncontrolled drinking.

An overall coordinating agency for services is needed in most communities. Otherwise, gaps in service will exist through which many alcoholic persons will fall, or costly duplications will occur. This coordination can be accomplished under the umbrella of a public health department, a comprehensive health or mental health organization, or some similar group. An important part of the coordinating body is a highly visible community education and referral service, similar to those affiliated with the National Council on Alcoholism. This referral service is a place to which to turn for help in finding the right spot to enter the treatment network. It can be used both for self-referral and to assist clergymen, physicians, courts, teachers, social agencies, and other health professionals coming in contact with people who have drinking problems or are addicted to alcohol.

An essential first level of treatment is detoxification for the acutely intoxicated person. Some communities might prefer a detoxification center, perhaps operated by a public health department, from which a patient can be referred to rehabilitative resources. Others might prefer to develop detoxification treatment at each community general hospital. A psychiatric hospital will be necessary for those who are a risk to themselves or others, or for those who must be hospitalized so they can obtain a handle on the beginning of long-range rehabilitation. A network consisting of general hospital psychiatric units, private free-standing psychiatric hospitals, and publicly supported mental health units—whatever is locally

appropriate—must be developed. Detoxification is merely emergency treatment, representing the first step toward recovery for the acutely intoxicated person. Unfortunately, the only medical service offered by many communities to alcohol abusers and alcoholic persons is a detoxification service and even when continuing services are provided, facilities are so inadequate that they discourage people from seeking, accepting, or continuing treatment.

Alcoholics Anonymous should be encouraged to participate in the system at an early point, and then re-introduced along the way for those who need special help before they can accept the Alcoholics Anonymous fellowship. Alcoholics Anonymous groups can be established at detoxification units, general and psychiatric hospitals, and clinics. As soon as possible, the patient should be out of a hospital; indeed, the majority will not need a hospital at all. For those still requiring much support, or without personal attachments, halfway houses and a partial hospitalization program should be developed.

Outpatient care may run the gamut from Alcoholics Anonymous, to special alcoholism clinics, to general psychiatric clinics, to private practitioners with special interest and skills in treating alcoholic persons. Therapy must be directed at both intrapsychic and interpersonal problems, sometimes with involvement of spouses and other family members.

Community consultation is essential for a well-functioning program. Professionals should be available to offer help at major case-finding points: the municipal court, the city jail, welfare departments, hospital emergency rooms, and social agencies. Consultation for education programs should be available to schools, clergymen, service clubs, and interested social groups.

Despite the best efforts of this community network, some alcoholic persons will be in an irre-



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versible state. For these people, social centers and sheltered living will have to be provided.

Many communities will find it necessary to bring in special organizations that work best with certain minority or ethnic groups. Indigenous workers should be trained and available as therapeutic intervenors at each step in the network of services.

In general, persons who need adequate medical coverage, and health and social resources as a result of their alcoholism, do not have the same services available—either from the private or public sectors of the nation—as persons with other illnesses. This has been due, in part, to this historic reluctance to commit incentive, personnel, or funds to this area of need. It is also due to the lack of clear-cut diagnostic procedures which can be used to determine the existence of the illness, alcoholism. Surprisingly, an inventory of resources will show that many of the needed treatment facilities actually exist in most communities. What is lacking is organization, coordination, cooperation and, most important, a dedication to see the alcoholic individual as a person worthy of care. Given some outside grant funding, the cost of supplying the missing links may be within grasp. Operational costs for the community will not be heightened; in fact, they will prove much less expensive than failure to operate such a system. Private health insurance carriers, through State regulatory bodies, should be forced to remove clauses in their policies that discriminate against alcoholism. The cost of providing care for the medically indigent patient will be minimal compared to ultimate public costs of neglecting him.

No one knows what proportion of alcoholic patients can be helped by a system providing such continuity of care. As with many medical and social disorders, alcoholism tends to be a chronic ailment with a myriad of causative factors. Control is the practical goal. Recovery may be temporary, but is vital to survival while it lasts, and temporary improvement allows optimism that control can be gained. To date, at any given time, a cross-section of alcoholic patients shows one third much improved (not only in alcohol-related behavior but in general living comfort), one third experiencing some lesser benefit, and one third unchanged. A slice across the sample at another time will show considerable shifting back and forth among these sectors. With such a success rate at present, we can expect our efforts to be correspondingly rewarded as we muster knowledge and resources in the future.

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Discipline Commission Action

Editor's Note: On instructions of the Council of the Medical and Chirurgical Faculty of the State of Maryland, "Findings of Fact, Conclusions of Law and Order," will be published in the MARYLAND STATE MEDICAL JOURNAL on a regular basis.

As cases become final after action by the Commission on Medical Discipline, they will be published in the manner of the case that follows. Others will be published as received from the Commission.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER IN THE MATTER OF JOSE A PAGAN-LUGO MD BEFORE THE COMMISSION ON MEDICAL DISCIPLINE OF MARYLAND

Upon the complaint of and after investigation by the Allegany County Medical Society and the Medical and Chirurgical Faculty of Maryland the Commission on Medical Discipline of Maryland determined to hold a hearing on charges that one Jose A Pagan-Lugo, a person licensed to practice medicine and surgery in the State of Maryland by the Maryland Board of Medical Examiners, had been guilty of immoral conduct in his practice as a physician. Such a hearing was subsequently scheduled for Oct 4, 1972 and appropriate notice of the time, date and place of the hearing and of the evidence upon which the charges were based was given to Dr Pagan in accordance with law. Thereafter, the hearing was postponed to Oct 18, 1972, at the request of the respondent's attorney. The hearing was subsequently held on Oct 18, 1972 at which time the respondent appeared and was represented by Hugh A McMullen, Esq, his attorney.

FINDINGS OF FACT

The Board heard testimony from Miss Linda Bolka, a resident of the State of West Virginia, Mrs Lois Bolka, her mother, also a resident of the State of West Virginia, and from Mr Donald F Simpson, Miss Bolka's fiance, of Cumberland, Md. In addition, the Board heard testimony from the respondent.

From the evidence before it, the Commission made the following findings of fact:

- 1) On Jan 10, 1972 Dr Pagan did in fact touch his hand and his mouth to Miss Bolka's breasts and did further request that she have oral sexual relations with him.
- 2) That Miss Bolka, by her reactions to Dr Pagan's advances, did not make it clear to him that she did not wish him to continue these activities.
- 3) That Dr Pagan had failed to respond in a meaningful way to efforts by constituent medical societies to obtain from him an explanation of the conduct with which he had been charged.

CONCLUSIONS OF LAW

From the foregoing findings of fact, the Commission concluded that he respondent was guilty of immoral conduct in his practice as a physician and that he was thus subject to the disciplinary powers of the Commission under the provisions of Article 43, Section 130 (k) of the Annotated Code of Maryland.

ORDER

Upon the foregoing findings of fact and conclusions of law, it is this 31st day of Oct 1972 by the Commission on Medical Discipline of Maryland,

ORDERED that Jose A Pagan-Lugo MD be and he is hereby REPRIMANDED and be it further

ORDERED that a copy of the foregoing findings of fact, conclusions of law and this Order be filed with the Board of Medical Examiners of Maryland pursuant to the provisions of Article 43, Section 130 (m) of the Annotated Code of Maryland.

/s/ JOHN M DENNIS MD, Chairman

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Maryland Association of Medical Assistants



Chief McMahon Dr Skinner

The reports that follow on monthly meetings of the Baltimore Chapter of AAMA-Maryland were submitted by Rita Corby CMA, Publicity Chairman, AAMA-Maryland.

January

Battalion Chief Martin C McMahon, Baltimore City Fire Department, at the January 9 meeting in the Medical Examiner's Office, took as his subject: "Heart and Lung Resuscitation."

With information provided by Chief McMahon, persons should be able to help save a life in an emergency.

A member of the Fire Department for 33 years, Chief McMahon has been in charge of their Ambulance Service—rated as one of the outstanding in the country—for 23 years.

He related his pioneering experiments in mouth-to-mouth and mouth-to-airway artificial respiration for the US Surgeon General (1956-1958) and his work with Johns Hopkins doctors (1959-1969) in the development of cardiopulmonary resuscitation.

February

The February 13 guest speaker was Mrs Jane Weiss, Medical Records, Church

Home and Hospital, Baltimore. In her topic, "Medical Records," she covered the intricate workings of such a hospital department.

Medical assistants not familiar with hospital work were amazed by the detail employed by the record room.

Mrs Weiss displayed and discussed all the forms needed on patients from the time the reservation is made to the day of discharge.

A computerized history is taken by the patient; the social security number is used on each patient as the identifying number of the history; and microfilm is used to store records. Manuals are given to all new doctors to orient them on hospital procedures.

March

Hubert G Skinner MD was guest speaker at the March 13 meeting. His subject: "Conservation Surgery of the Larynx for Cancer."

This was primarily a discussion of partial resection of the larynx, as opposed to the standard total laryngectomy, thereby conserving the laryngeal function and speech.

Dr Skinner showed slides that were helpful in explaining this procedure.

A practicing Baltimore physician, Dr Skinner has staff privileges at several Maryland hospitals.

May

"What Price Health" was the subject of the presentation by Jack Zimmerman MD at the May 8 meeting.

Dr Zimmerman, Chief of Surgery at Church Home and



Dr Zimmerman

Hospital and Associate Professor of Surgery at Johns Hopkins Hospital, spoke to the membership in his capacity as Chairman of the Public Medical Education and Public Relations Committee of the Baltimore City Medical Society.

The meeting, held in the Medical Examiner's office, was preceded by a buffet supper.

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PACEMAKER—South Baltimore General Hospital's recently opened Pacemaker Clinic provided a good pacemaker surveillance system which permits elective replacement of a pacemaker most of the time. In the photo, Technician Carla Clifton, seated at Pacemaker Check System (top to bottom: Signal Splitter, Time Counter, Oscilloscope), checks performance of patient's permanently implanted pacemaker with Dr Lawrence F Awalt, Associate Cardiologist. According to Dr Chris Papadopoulos, Chief of Cardiology, "the main function of the clinic is to provide monitoring of pacing and battery function and to obviate the need for emergency battery replacement and yet extend as far as possible the life of the battery."

When You Can't Get to Sleep . . .

Insomnia plagues many people. If you're among its victims, Prof A N Landyshev of California State Polytech has some comments and advice to offer:

1) Try eating your large meal of the day at noon, instead of at night. A brisk walk for 15 minutes or a brief session of stretching exercises often aids relaxation.

2) A tepid—*not hot*—bath also can help.

3) Finally, you've got to learn to turn the light off on all problems once you are ready to hit the sack.

4) Sleep environment is an important factor, too. Prof Landyshev describes the "ideal" bedroom as large, well-ventilated, with a firm bed and as little clutter as possible. He suggests a modernized revival of the old fashioned feather-bed, somewhere between the hardness of a wooden floor and the softness of a hammock. "You should never use perfume, cologne, deodorizers, food or drinks in the bedroom" declares the professor.

Other recommendations: wall-to-wall carpeting to cut down noise, noiseless air-conditioning

and filtering of air to reduce pollutants, and an unvarying bedtime ritual. A timer plus radio or tape cassette is also helpful. Recorded heartbeats at 72 beats per minute work wonders in transporting some people to dreamland. If sleep still eludes you, try throwing off the covers until you get chilly; then pull them on again. Or spread a light comforter or blanket on the floor and sleep there. Some people report that the best sleep of their lives comes when they do this.

Med-Chi members are invited to write to the editor expressing their opinions or giving information on matters of mutual interest. The Editorial Board reserves the right to select or reject communications. As with other material, all correspondence will be subject to the usual editing and possible abridgement. Material should be typewritten, double spaced, of reasonable length, and not over two pages. Address: The Editor, MARYLAND STATE MEDICAL JOURNAL, 1211 Cathedral St, Baltimore Md 21201.

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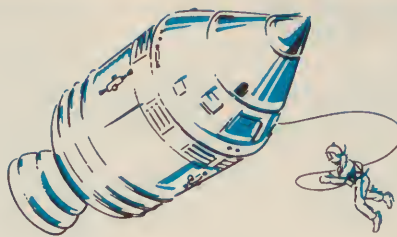
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The Emerging Speciality of the Emergency Department Physician

WILLIAM T HAECK MD

Project Director

Emergency Medical Services Section
Division of Health, State of Florida

The emergency physician is a unique entity in American Medicine. He was created by public demand. During the 50s and 60s increasing public mobility, decreasing availability of family physicians, and increasing demands of the consumer for immediate care led many individuals to begin to seek care in emergency departments. Visits to emergency departments over a ten-year period rose by 300% in some places.

The hospital and its medical staff share a joint responsibility to treat any patient who arrives at the hospital emergency department seeking care. The increasing visit load in the emergency department increased the work load of already busy hospital medical staffs. Many staff members also began to feel uneasy about being responsible for complicated cases they might not have seen or treated since the time they started specializing.

Hospitals and their medical staffs developed two generally accepted plans to meet their obligation to treat emergency patients and to free the medical staff to meet all their other obligations. The plans were named for the cities and hospitals where they first evolved.

The Pontiac Plan ensures that there will be a physician on duty in the emergency department 24 hours a day. This physician and his partners (sometimes as many as 40 or 50) maintain their medical practices and agree to be present in the emergency department when assigned there by the group leader.

The Alexandria Plan is a further refinement. It also guarantees the presence of a physician in the department 24 hours daily. In this plan, the physicians in the department limit their practice to emergency medicine and their entire med-

ical practice is limited to the department.

Many physicians are now making careers of emergency medicine. They have obtained special training to give them expertise in resuscitation, wound care, correction of shock, acute heart problems, and many acute and common problems of everyday medical practice. Their practices involve stabilization of acute problems and initial treatment of nonlife-threatening problems and referral of the patient for definitive care. In many instances, the emergency department is now the point where patients enter the health care system.

Many emergency physicians are serving their communities by actively becoming involved in stimulating them to upgrade and improve the total emergency medical services system in the community. They are often in the battle lines fighting for improved ambulance services. Many are out in the community teaching the principles of good first aid and cardiopulmonary resuscitation. They are involved in training ambulance attendants and are involved in the struggle to bring local, state, and federal laws up to date to legislate the improved EMS systems this country needs.

Organized medicine is starting to recognize the expertise of the emergency physician. Some state medical societies recognize emergency medicine as a specialty. Medical schools are beginning to train young physicians in emergency medicine as a primary career.

The emergency physicians have organized to form the American College of Emergency Physicians. It now has over 3000 members. University Emergency Department Physicians have organized the University Association for Emergency Medical Services. Both groups are fighting for better emergency care for the American public through better training for emergency physicians, better quality emergency departments, and better community emergency care systems.



PAUL F GUERIN MD
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Has your society ever invited a representative of the Faculty library to attend your meetings? Or, would you like a selection of books and other pertinent library materials sent to you for exhibit during your meetings?

If you do, all you need to do to secure this service is notify the librarian far enough ahead for plans to be made to attend or collect materials to be sent. Knowing the program subject would help in the selection of titles and preparation of appropriate bibliographies to accompany the collection.

In line with the regular component society meetings, if you have seminars, symposia, or continuing education courses any time, we will be glad to furnish supplementary texts and journal articles related to the subjects being discussed.

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REFERENCE WORKS

- Ref. Ellingson, Careth
 HD **Directory of facilities for the learning-disabled and handicapped.** New York, Harper & Row, 1972.
 7256
 .U5
 .E4

BACTERIOLOGY

- QW Kauffmann, Fritz
 15 **Serological diagnosis of Salmonella-species, Kauffmann - White - Schema.** Copenhagen, Munksgaard, 1972.
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 4 **Microbiology.** New York, Appleton-Century-Crofts, 1972.
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CARDIOVASCULAR SYSTEM

- WG Miller, Benjamin Frank
 113 **Freedom from heart attacks.** New York, Simon & Schuster, 1972.
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 168
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 500 **Chronic diseases and public health.** Baltimore, Johns Hopkins Press, 1966.
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- WK Bruining, H A
 300 **Surgical treatment of hyperparathyroidism.** Assen, Van Gorcum, 1971.
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- WH Miale, John B
 100 **Laboratory medicine: hematology.** 4th ed. Saint Louis, Mosby, 1972.
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 WH **Molecular aspects of sickle cell hemoglobin; clinical applications.** Springfield Ill, Thomas, 1971.
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 WH Rapaport, Samuel I
 100 **Introduction to hematology.** New York, Harper & Row, 1971.
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HOSPITALS

- WX Bouchard, Vincent E
 179 **Staffing patterns in hospital pharmacy.** Pittsburgh, Duquesne Univ Press, 1970.
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 179 **Manual for pharmacy technicians.** Saint Louis, Mosby, 1972.
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INFECTIOUS DISEASES

- WC Top, Franklin H
 100 **Communicable and infectious diseases.** Saint Louis, Mosby, 1972.
 .T6

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- W Allen, Richard
 740 **Readings in law and psychiatry.** Baltimore, Johns Hopkins Press, 1968.
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- WB Mann, Felix
 369 **Acupuncture: cure of many diseases.** Boston, Tao books Publications inc, 1972.
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- WE Bateman, James
 810 **The shoulder and neck.** Philadelphia, Saunders, 1972.
 .B3
 WE Hollander, Joseph
 344 **Arthritis and allied conditions; a textbook of rheumatology.** Philadelphia, Lea & Febiger, 1972.
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- WW Casey, T A
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- WL Goldberg, Herman
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PHYSIOLOGY

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255 **Total fitness.** San Francisco, Canfield Press.
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PSYCHIATRY

- HQ American Medical Association. Committee on
56 Human Sexuality.
.A5 **Human Sexuality.** Chicago, 1972.
WM Beigel, Allan
30 **The community mental health center: strate-**
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WM Lion, John
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- Z Christ, John
695.1 **Concepts and subject headings: their relation in**
.S6 **information retrieval and library science.**
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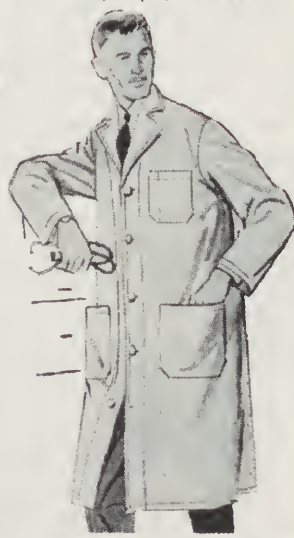
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FRANCIS X CARMODY MD
Journal Representative

Baltimore City Medical Society

Board of Directors Acts

The Board of Directors met on January 9 and took the following actions:

Approved the minutes of the Dec 12, 1972 meeting.

Appointed a committee to view the TV program "What Price Health."

Referred a request for Emeritus Membership to the Membership Committee for further review.

Directed that a letter be written to an applicant who had failed to attend several orientation meetings stating that if he did not attend the next session his application would be returned.

Agreed that the March 1 meeting of the Society should be held in conjunction with an oyster roast at Martin's West.

Approved the request of the Environmental Problems Committee to expend \$400 to produce an exhibit for the Med-Chi Annual Meeting. The exhibit will also be made available to schools in the City.

Heard a report from the Committee on Drugs that articles had been submitted to the *Maryland State Medical Journal* for publication and that several hospitals in the area have requested the Committee to present programs on the emergency treatment of drug overdose patients to their hospital staffs.

Agreed to support an eight-hour postgraduate course for physicians on the treatment of drug problems to be sponsored by the Committee on Drugs.

Denied the request of the Committee on Drugs to expend funds to purchase reprints of the articles printed in the *Journal*.

Requested the Bylaws Committee to formulate an amendment to the Bylaws which would allow the deans of the two medical schools to be conference members of the Board of Directors, with voice but no vote.

Approved the continuation of holding meet-

ings with the Chiefs of Medical Staffs and the Society officers. This, hopefully, will enhance the relationship among all segments of the medical community.

Approved the resolution concerning the location of the Med-Chi headquarters and library which was submitted at the January general meeting.

The Board of Directors met on February 13 and took the following actions:

Approved the minutes of the January 9 meeting.

Waived dues for a member who is unable to practice because of illness.

Accepted the report of the Policy and Planning Committee on the AMA Survey Report and referred some recommendations back to the Committee for further consideration.

Accepted with appreciation the reports of Dr Rachel Gundry, the Society's representative to the Regional Planning Council's Project Review Committee.

Accepted the financial statements presented.

Accepted the recommendation of the Committee to Review Research Protocols to approve a study on smoke inhalation by the Department of Environmental Medicine, the Johns Hopkins School of Hygiene and Public Health.

At the request of the Committee on Drugs, endorsed the program for addicted mothers being carried out by Baltimore City Hospitals; endorsed the priorities listed by the Mayor's Office on Drug Abuse Control; and voted to cosponsor the Regional Medical Program's Second Monday Series on the Emergency Treatment of Drug Overdose to be held March 12 and 13.

Read a letter of thanks and praise to the Committee on Drugs for the program presented to the staff at North Charles General Hospital on emergency treatment of drug overdose patients.

Voted to submit the name of Helen B Taussig MD to the Sheen Award Committee to receive this yearly award.

Approved the wording of a resolution regarding the location of the Med-Chi headquarters and library to be submitted to the Med-Chi House of Delegates at the April 1973 meeting.

Agreed to ask the opinion of legal counsel on actions taken against the membership of a physician if he does not comply with recommendations made by the Peer Review Committee for the upgrading of his practice.

Accepted and approved the report of the Nominating Committee. The Committee submitted names to the Medical and Chirurgical Faculty Nominating Committee for consideration in selecting officers for the 1973 slate.

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Commissioner

Baltimore City health department

TB Patients Needed For Treatment Study

Baltimore City physicians or other physicians treating tuberculosis patients who reside in Baltimore City are invited to submit the names of their patients for an ongoing "TB Ambulatory V Hospital Treatment Study." This request is made by the study team of Dr Allan S Moodie, Director of the City Health Department's Bureau of Communicable Diseases, and Dr Richard L Riley of the Department of Environmental Medicine of the Johns Hopkins School of Hygiene and Public Health.

Begun early in 1972 with financial support from the National Tuberculosis and Respiratory Disease Association, the project proposes to measure the relative effects of home versus hospital treatment on cases of tuberculosis and their contacts.

The postulate: An individual diagnosed as suffering from active tuberculosis, who is ambulatory and not incapacitated by tuberculosis or other concomitant disease, will respond to drug therapy just as well at home as he would in hospital, that he can be motivated to attend for treatment with an adequate degree of regularity at a reasonable additional expenditure of staff effort, and that this can be achieved without additional risk of infection to household contacts.

Criteria for admission to the study follows:

- 1) Patient diagnosed as having "active pulmonary tuberculosis"
- 2) Between 15 to 70 years of age
- 3) No serious complicating disease
- 4) Less than 21 days previous antituberculosis drugs
- 5) No previous or current psychiatric problems
- 6) Must have permanent address in the City of

Baltimore and be available for follow-up by the Baltimore City Health Department

- 7) Patient must be ambulatory in order to take part in the study

Patients included in the study are randomly allocated to home or hospital treatment and all family contacts are closely followed. To date, cooperation by patients has been excellent and the results of treatment have been very satisfactory.

Unfortunately, according to Dr Moodie, the intake of patients has been very slow. More than 90% of suitable patients first diagnosed at city chest clinics have been included in the study; on the other hand hospitals and private physicians who contribute three quarters of all new case reports have entered only nine out of 300 new cases.

Physicians are asked to keep this study in mind and enter patients who conform to the above criteria. This can be done by notifying Dr Elmer P Sauer, Medical Superintendent at Mount Wilson Hospital, phone 486-7676. For those interested, copies of the protocol may be obtained from Mrs Nancy Heil, Baltimore City Health Department, phone 752-2000, ext 2569.

Home Oil Burner Survey

The City Health Department is conducting a home oil burner survey to check on the efficiency of residential furnaces.

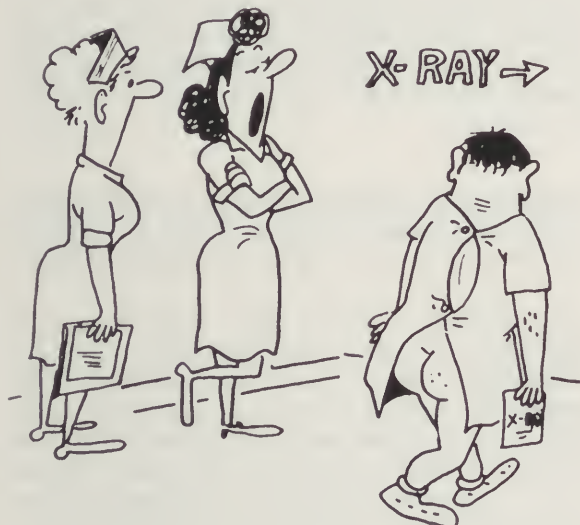
The new survey is one of a continuing series of efforts by the City Health Department to assess Baltimore's air pollution problems. It will give the Department some indication of the extent of pollution caused by home oil burners.

Mr Elkins W Dahle Jr, Director of the Bureau of Industrial Hygiene, said the pollutant emission survey will be conducted by three teams consisting of engineers and industrial hygiene sanitarians and should be completed by early

May for this heating season. The project will be continued during subsequent heating seasons.

According to Mr Dahle, inefficient burners not only produce more pollution but they also waste oil and money and can cause explosions or fires. In addition to evaluating the burner and flue, all inspectors will be alert to the possibility of fire hazards in connection with the furnace operation and will make the necessary recommendations to the occupant to correct the situation.

Physicians who would like to participate in this study may call the Bureau of Industrial Hygiene's air pollution division, phone 752-2000, from 8:30 AM to 4:30 PM and ask for the oil burner testing project. The project has the cooperation of Oil Heat Association of Maryland Inc, and is being conducted under the joint direction of Messrs Don Torres and Buckley Harris of the Bureau of Industrial Hygiene.



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EDUCATING PERSONNEL FOR THE ALLIED HEALTH PROFESSIONS AND SERVICES, by Edmund J McTernan MPH, and Robert O Hawkins Jr EdM, The CV Mosby Co, St Louis, 1972.

The authors have combined into one source the contemporary thinking on a number of issues of great concern to persons responsible for organizing, planning and administering educational programs in the allied health field. They have accomplished this by calling on 22 outstanding contributors from throughout the country.

The book concentrates on interest areas of greatest import and emphasizes principles rather than specifics. We believe this book is a must for any person involved in education of allied health professionals.

COMMUNICABLE AND INFECTIOUS DISEASES, by Franklin H Top Sr MD, and Paul F Wehrle MD, The CV Mosby Co, St Louis, 1972.

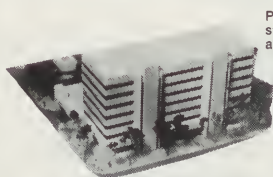
The list of distinguished contributors is illustrious and contains many names that are familiar to persons active in this field. This marks the seventh edition of this publication, which has been updated continuously since the first was published in 1941. Needless to say the scope of the book continues to expand and new chapters have been added to even this edition.

This should be bought by those persons who have purchased previous editions, and it serves as an outstanding work for all those concerned about being up to date in their knowledge of this field.

HANDBOOK OF MEDICAL TREATMENT, by Milton J Chatton MD, Lange Medical Publications, Los Altos, Calif, 1972.

This is the 13th issue of this publication devoted to this subject. The material is presented in a concise, easy-to-read format; it is fully indexed for easy reference. It is almost a must for the conscientious busy physician who wants to ensure he is up to date in all aspects of medical treatment being rendered his patients.

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MANUAL FOR PHARMACY TECHNICIANS, by Sister Jane M Durgon BS, Charles O Ward BS, and Zachary I Hanan BS, The CV Mosby Co, St Louis, 1972.

This manual is intended as a guide in the development and training of pharmacy technicians. The authors take the position that more and more pharmacists are being asked to assume more responsibility requiring judgments based on professional and scientific knowledge. As these responsibilities expand, there is a need for supportive personnel to assume the technical responsibilities of pharmacy activity

The manual is based on a lecture series developed at Mercy Hospital, Rockville Centre, NY. It is an eight-month program first initiated in 1965. As a result of requests for background material and data, this publication was developed.

Its emphasis is on a professional appreciation of pharmacy rather than the specific development of skills. This is the first published text in this area and is receiving more attention from proponents of increasing the responsibility of the pharmacist.

HERITABLE DISORDERS OF CONNECTIVE TISSUE, by Victor A McKusick MD, C V Mosby Co, St Louis, 1972.

The author of this book is a distinguished professor from the Johns Hopkins University School of Medicine and is well-known to readers of this Journal. The bulk of his career has been devoted to genetics and its related problems. This book is a result of the intense study and concern of Dr McKusick in this area of medicine.

He states that many divisions of medical science have a concern with the problems of generalized and hereditary disorders of connective tissue and proceeds to list them by specialty and subspecialty. He also includes the medical student in his listing of those who have such concerns. He flatly states: "... clinical investigation of pathologic states is as legitimate a method as any other for studying biology."

In the acknowledgements section, the list sounds like a veritable Who's Who of prominent physicians in the medical field, including many from the Baltimore area, both living and dead. He also gives credit to many of the conferences sponsored by the Johns Hopkins Medical Institutions as well as to the National Foundation—March of Dimes and others.

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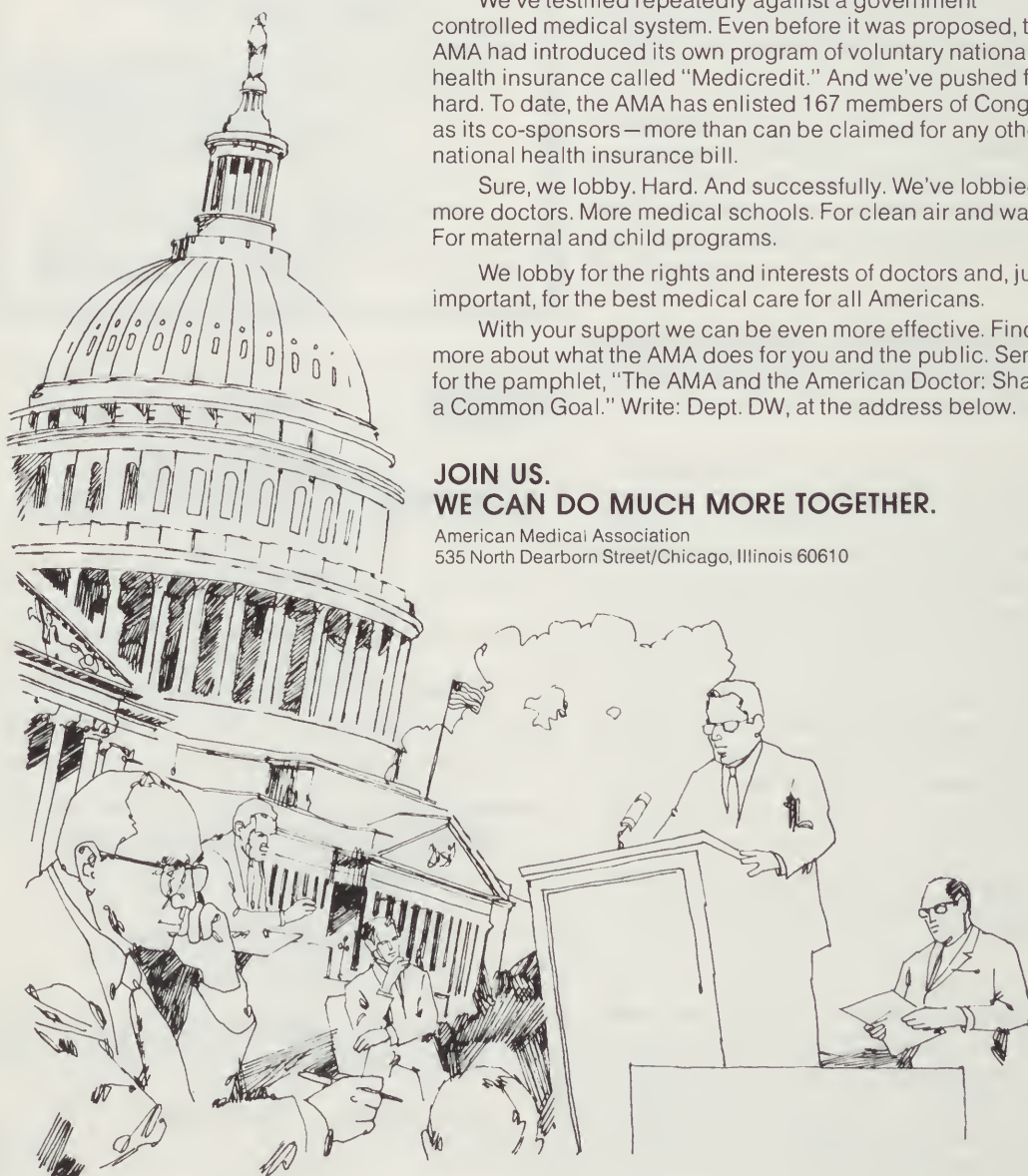
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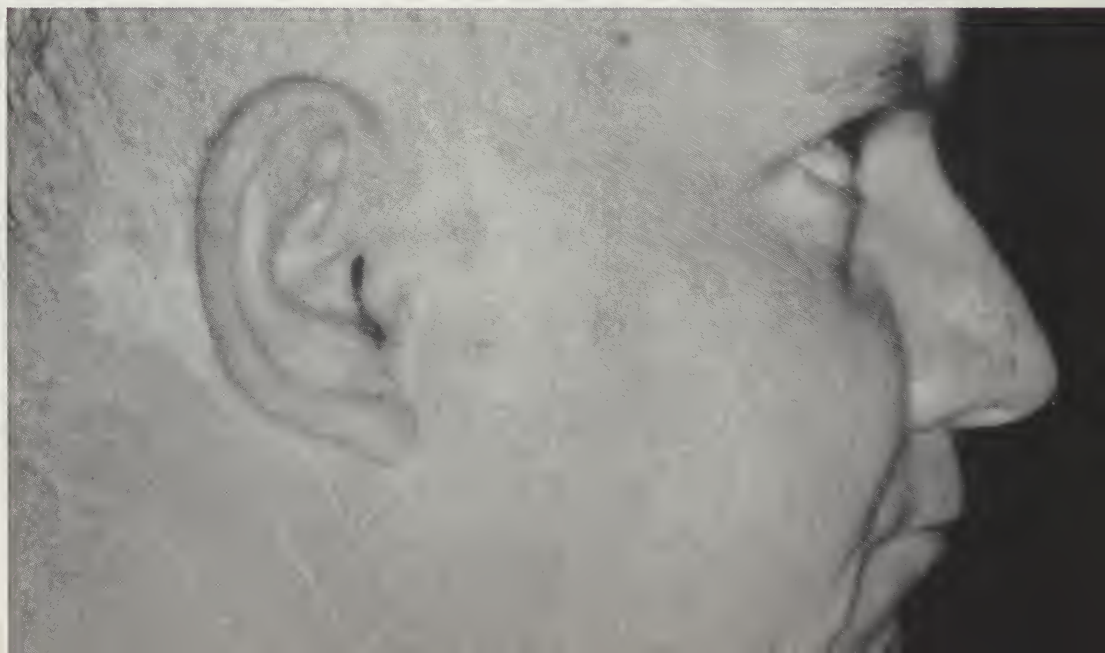
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WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3 ?

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1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

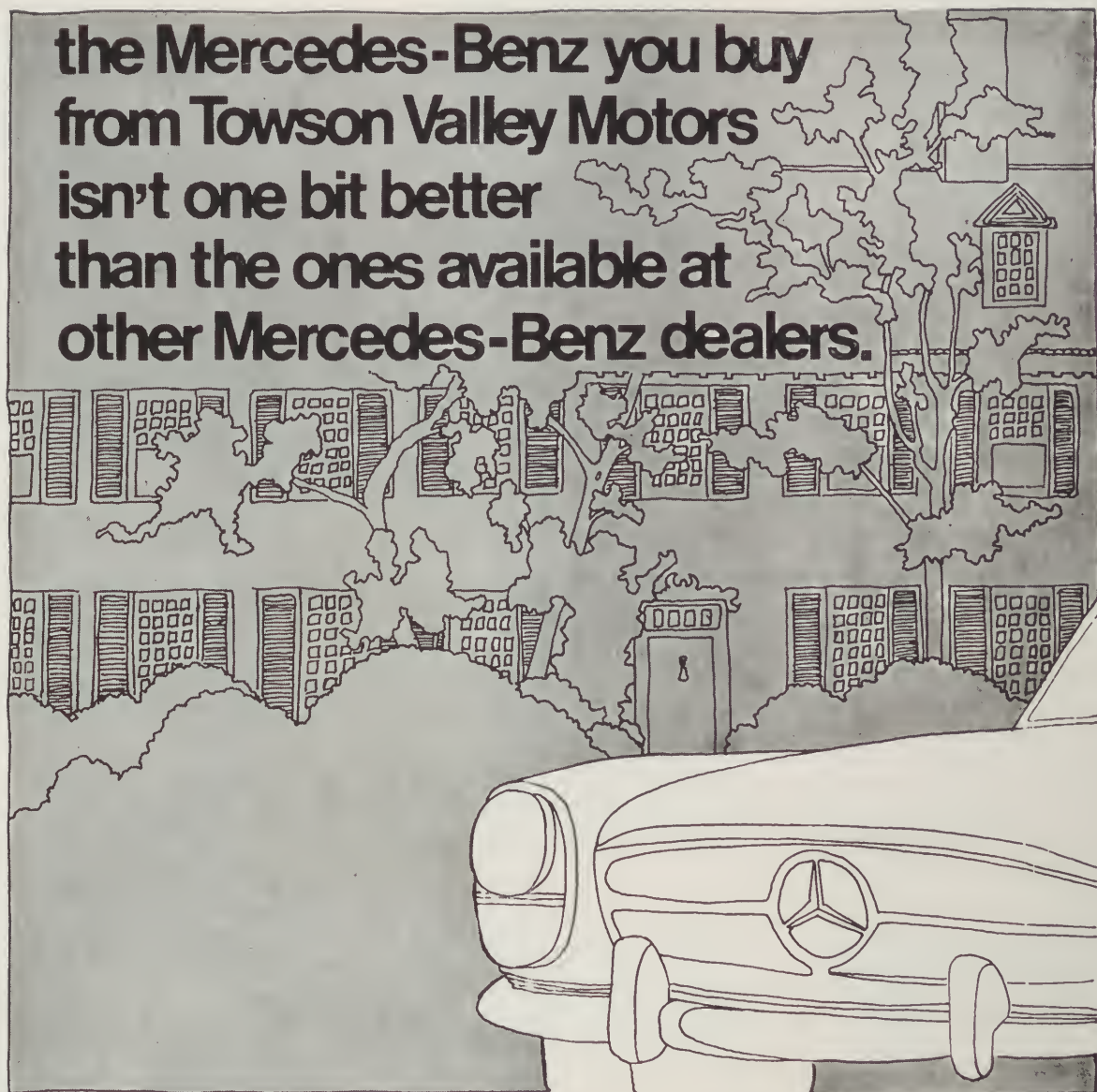
Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



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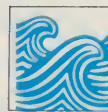
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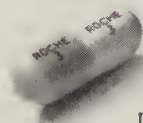
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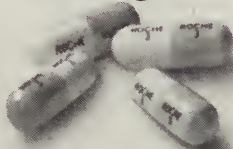
As strong as Librium® 25 mg (chlordiazepoxide HCl)



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For over 13 years, Librium has been recognized for its excellent benefits-to-risks ratio, an asset in the *higher* dosage ranges as in more common clinical applications. Thus, the frequency of dosage with Librium 25 mg can be flexibly adjusted to the needs and response of the individual patient, up to 100 mg daily if required. Total daily dosage for the elderly and debilitated should not exceed 20 mg. When severe anxiety has been reduced, Librium dosage should be correspondingly reduced or discontinued entirely.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

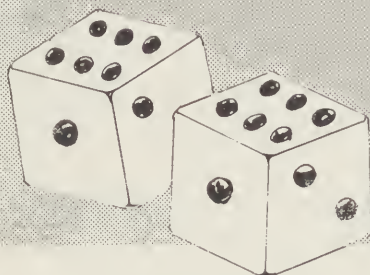
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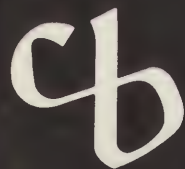
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In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

Tandearil® helps take the heat off oxyphenbutazone NF Geigy

Tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasias); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonamide, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

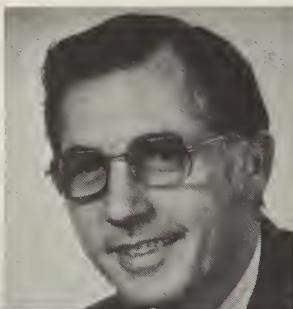
For complete details, including dosage, please see full prescribing information.

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"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
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Maker of Medicine

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"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients . . .

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 2

ould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making a substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could allow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MISCELLANEOUS MEETINGS

- | | | |
|-----|-------|---|
| Jun | 17-20 | Lifesaving Measures for Critically Injured, Seminar , Mills Hyatt House, Charleston SC. Sponsors: ACS Comm on Trauma & Dept of Surgery, Med Univ of South Carolina. \$45 regis, 21 hrs cr. Info: Dr Max Rittenbury, Dept of Surgery, Med Univ of South Carolina, Charleston SC 29401 (803) 792-3961. |
| Jun | 22-23 | Emergency Dept Legal Institute , O'Hare Regency House, Chicago. Sponsor: ACEP & Hlth Law Cen of Aspen Systems. Contact: R T Johnson, ACEP, 241 E Saginaw St, East Lansing Mich 48823. |
| Jun | 22-23 | Amer Assoc for Study of Headache , anl mtg, Plaza Hotel, New York City. Sponsor & Contact: Amer Assoc for Study of Headache, 5252 N Western Ave, Chicago Ill 60625. |
| Jun | 23-24 | AMA Anl Mtg , New York. Contact AMA, 535 N Dearbon St, Chicago Ill 60610. |
| Jul | 8-19 | Summer Program in Human Sexuality , Bloomington Ind. Sponsor & Contact: Indiana Univ Institute for Sex Research, Morrison Hall 416, Bloomington Ind 47401. |
| Jun | 22-24 | ACR Seminar on Skeletal System , Amer Col of Radiology, New York. Info: ACR, 20 N Wacker Dr, Chicago Ill 60606. |
| Sep | 6-8 | Amer Assoc of Ob&Gyn , Hot Springs, Va. |
| Sep | 14-16 | ACR Seminar on the GI System , Amer Col of Radiology, Houston. Info: ACR 20 N Wacker Dr, Chicago Ill 60606. |
| Sep | 17-18 | 33rd Anl Congress on Occupational Health , Benj Franklin Hotel, Philadelphia. Info: AMA Dept of Environmental, Public & Occupational Health, 535 N Dearborn St, Chicago Ill 60610. |
| Sep | 17-21 | Neuroradiology , Harvard Med Sch, Boston. Info: Harvard Med School, Dept of Con Med Educ, 25 Shattuck St, Boston Mass 02115. |
| Sep | 19-23 | Med-Chi Semianl Mtg , Camino Real, Mexico City. |
| Sep | 20-21 | Emer Dept Legal Institute , O'Hare Regency Hyatt House, Chicago. Sponsor: ACEP & Hlth Law Cen of Aspen Systems. Info: R T Johnson, ACEP, 241 E Saginaw St, East Lansing Mich 48823. |
| Sep | 27-29 | 2nd Natl Conf on Cancer of Colon & Rectum , Americana Hotel, Bal Harbour Fla. Sponsor: Amer Cancer Society. Info: Dr S L Arje, c/o Amer Cancer Society, 219 E 42nd St, New York NY 10017. |
| Oct | 20-21 | 1973 Certification Exams , American Board of Family Practice, various locations. Contact: Dr N J Pisacano, Amer Board of Family Practice, Univ of Kentucky Med Cen, Annex 2, Room 229, Lexington Ky 40506. APPLICATIONS DEADLINE IS AUG 1. |



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Cooling Down Health Care's Crisis Rhetoric

BY GEORGE MELLOAN

"Crises" come and go like buses these days, often propelled by politicians and journalists and sometimes by actual events—it remains for the public to decide what is for real and what is mostly illusion.

One such choice between reality and illusion has to do with the problems of health care in America, which got "crisis" status a couple of years ago, largely through the efforts of Sen Edward M Kennedy. Senator Kennedy not only labeled health care a "crisis" area but also offered a remedy for the crisis, a \$60 billion federal health insurance scheme.

Much to its credit, the electorate was not buying. While everyone knew that the cost of medical care had risen sharply in the late 1960s, public dissatisfaction with the rising costs did not equate with crisis. Throughout the so-called crisis, public opinion polls suggested that most Americans were happy enough with their own doctors and with the quality of medical care available to them.

It remained, however, for someone to spell out in some detail why there is nothing approaching a crisis in health care and to put the problems associated with medical care into some sort of perspective. That service has been performed admirably by Harry Schwartz, a member of the editorial board of *The New York Times* who is better known as a Sovietologist than as a medical writer. His book examining American medicine deserves the subtitle it carries: "A Realistic Look at Our Health Care System."

What is refreshing about Mr Schwartz' book is that in this era of impassioned rhetoric and polemics it finds few devils. It treats doctors, medical societies, and health insurance providers not as a giant conspiracy against the helplessly ill and indigent but as a collection of generally able and industrious individuals providing a complex and highly diversified service. He not only destroys the "crisis" claims but is highly skeptical of any notion that all these people can somehow be put to work for a federal health care bureaucracy without real damage to the nation's health, political as well as physical.

Mr Schwartz says flatly at the beginning of his book that he will demonstrate that "a 'health care crisis,' or a 'health crisis' in the terms the propagandists usually present the matter, does not exist."

The terms Mr Schwartz refers to were the frequent claims at the zenith of the crisis talk that

American health has been deteriorating as a result of a free enterprise method of health care delivery and that it is inferior to the level available in a great many less-affluent nations.

First of all, Mr Schwartz demonstrates, the incidence of illnesses that can be controlled has fallen sharply. Between 1960 and 1971 the number of reported cases of six once-common diseases—measles, diphtheria, whooping cough, polio, tuberculosis and typhoid fever—declined to about 114,000 from roughly 517,000. Among seven common infectious diseases, pneumonia is the only one that still has a significant death rate and that has declined 60% since 1940.

Health crisis claims made much of the fact that 12 other nations have a lower infant mortality rate than the United States. Mr Schwartz examines some of the statistical and demographic flaws of infant mortality comparisons between the United States and tiny countries such as the Netherlands, which has the lowest rate in the world. He also shows that a low rate of infant mortality and a high availability of medical care do not necessarily go hand in hand, even in this country. North Dakota and Idaho have fewer doctors relative to the population than Louisiana and North Carolina and they also have lower infant mortality rates.

Infant mortality correlates more closely with the social and economic conditions in the state than with the availability of doctors, Mr Schwartz argues. At that, infant mortality has declined sharply and life expectancy has risen sharply in the United States in recent years.

Were it not for the claims that a health crisis exists, it would hardly seem necessary for Mr Schwartz to cite these statistics. Most Americans who have reached middle age are well aware of the improvements in the medical care that have occurred in their lifetimes.

But cost is another matter and dissatisfactions with cost are indeed a subject of some political and economic importance. It matters little that some of the sharp rise in hospitalization costs in the late 1960s can be directly attributed to the sudden demand created by Medicare. A Senator who claims that still another, larger federal insurance scheme can control costs is not likely to be completely ignored.

But Mr Schwartz argues that, by and large, with existing insurance schemes medical care for most people is relatively cheap, compared with, say the

cost of operating a car. He admits that there are indeed cost problems, but he argues that they should be approached with specific remedies rather than a grandiose medical insurance bureaucracy. The Nixon administration already is moving against the tendency of Medicare insurance to bring overutilization of hospitals through a proposed plan that would tie the Medicare patient's out-of-pocket costs more closely to the length of his hospital stay up to a point but give him greater protection against long-term illness.

The cost of a catastrophic illness is, of course, a serious problem and Mr Schwartz suggests that it could be solved by a national system of catastrophic illness insurance, which would be much more limited in scope and specific to the real problem than a general system of insurance.

But the main thrust of the Schwartz book is to introduce a more rational way of thinking about the nation's health problems. It is a way of thinking that does not paint the nation's doctors and other health workers as greedy parasites and does not seek to force them to submit to a coercive federal bureaucracy. To assume that free Americans of any profession are going to easily submit to such a system is rather unreasonable.

It argues that changes in the medical system will not bring the quickest changes in the nation's health over the next decade. "The most important road to better health and greater longevity for Americans lies in fundamental changes in lifestyle away from patterns that conduce to sickness and early death and toward new patterns that promote well being," Mr Schwartz says. By this he means reduced air pollution, lower consumption of fats, alcohol and drugs, effective gun control and safer driving.

"For the poorest Americans, what is required is alleviation of their poverty in ways that promote their integration as useful members of society," thus eliminating poor nutrition, poor housing and other "despair-producing" conditions, he adds.

But most important of all, he counsels against the myth that government can produce magic answers which politicians of the Kennedy persuasion persist in spreading. It is a myth that dies hard, "despite debacle after debacle in education, housing, mail service, military production and other areas," says Schwartz. "Must American medicine become another disaster area before the lesson is learned?" It is a good question and one that is entirely cogent to our times.

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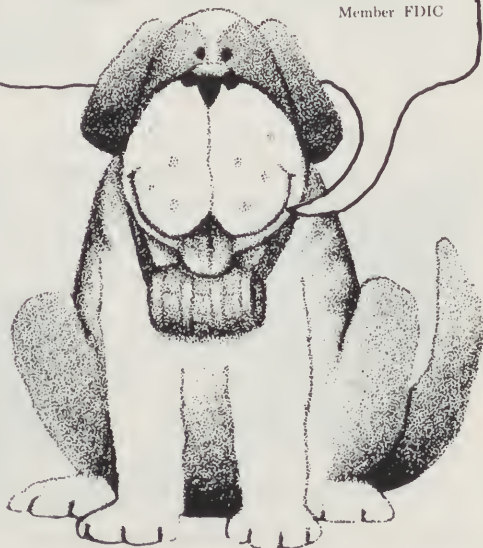
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Dr Maumenee

The Board of Trustees of the Johns Hopkins Hospital has changed its bylaws to include as an ex-officio member the Chairman of the Medical Board.

The Chairman, currently **A Edward Maumenee MD**, will have full voting rights. Unlike other trustees, who are lifetime members, he will be a member only as long as he is Medical Board Chairman.

Dr Maumenee is Professor and Chairman of the Department of Ophthalmology.

Ataollah Golpira MD, an internist, has been elected President of the Medical Staff, North Charles General Hospital, Baltimore.

Doctors in the News

Having assumed the positions of Assistant Professor of Medicine of the George Washington University School of Medicine and staff physician in the Division of Cardiology of the GWU Medical Center, **William S Byers MD** has closed his private practice of Cardiology and Internal Medicine in Easton.

The Passano Foundation Inc, Baltimore, advises that **Dr Roger W Sperry** has been selected to receive the \$10,000 Passano Award for 1973, one of the highest awards in American Medicine.

Quoting from their news release:

"This biologist, from the California Institute of Technology, has demonstrated through research into the functions of the surgically disconnected hemispheres in animals as well as human beings that two distinct minds can coexist in mutual ignorance of each other within one skull. His research had led to a better understanding of the mind/brain relation and the neurological bases of human behavior."



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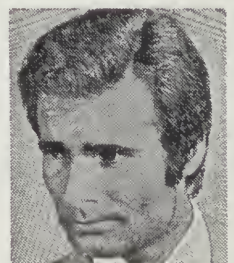
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Medical Miscellany

Hyper-immune Hepatitis-B Globulin Studies

Two clinical studies of interest to practicing physicians and paramedical personnel are currently being conducted in the Washington-Maryland area involving the use of hyper-immune hepatitis-B globulin. The studies have been spurred by the rapid increase in reported cases of serum hepatitis and the recent availability of gamma globulin with a high titer of antibody against the offending agent (Australia Antigen).

The first study involves the administration of hyper-immune hepatitis-B globulin to patients with acute fulminant hepatitis secondary to serum hepatitis. Recent reports indicate the potential therapeutic usefulness of high-titer globulin in this clinical situation; the study is designed to evaluate its efficacy in a randomized, double-blind trial. Many hospitals in the Washington and Maryland areas have been notified and the study is open to all physicians with patients with this clinical picture. Further information may be obtained by contacting Dr Hyman J Zimmerman or Dr James Kane (Area code 202-483-6666, ext 337), at the Veterans Administration Hospital, Washington DC.

The second study is designed to evaluate the efficacy of this high-titer globulin in preventing hepatitis resulting from accidental exposure to contaminated blood via needle-stick or ingestion. The study is randomized and double-blind, utilizing either the conventional gamma globulin normally employed or the hyper-immune type and is open to any person who may be exposed. Further information may be obtained by contacting either Dr Finkelstein (483-6666, ext 293) or Dr Seeff (483-6666, ext 241 or 242), at the Veterans Administration Hospital, Washington DC.

Breast Cancer Study

The cooperation of physicians is requested in the referral of patients with breast cancer for studies being conducted by the National Cancer Institute's Medical Breast Unit in cooperation with the Surgical Breast Program at the Clinical Center, National Institutes of Health, Bethesda Md.

They are interested in following patients with primary breast carcinoma and outpatients referred for a suspicious breast lesion. Of especial

interest are those patients who have positive axillary nodes found at surgery.

Physicians interested in further details and in having their patients considered for admission may write Dr Douglass C Tormey, Medical Breast Unit, National Cancer Institute, Bldg 10, Rm 6B17, Bethesda Md 20014, or phone (301) 496-1547.

Turn in a Pusher

The Turn-In-A-Pusher (TIP) program, recently begun by the Baltimore County Chamber of Commerce to help combat drug abuse in the Metropolitan Baltimore area, resulted in 165 phone calls the first week.

TIP offers citizens a way to anonymously report activities of drug pushers. TIP also offers a cash reward of up to \$500 to persons who call TIP headquarters at 823-3600 with information leading to the arrest and conviction of drug pushers.

Here's how TIP works. The phone is answered, "This is the TIP line; please do not give your name." A code number is assigned to the TIPster. TIP information is forwarded to the appropriate law enforcement agencies.

Arrests cannot be made on the basis of phone calls alone. The TIP must be verified through law enforcement investigation.

TIP's phone lines operate around the clock and are manned by trained personnel capable of screening out crank, false, or malicious calls.

To collect the cash reward, the TIPster calls the TIP line and reports the code number previously assigned. After verification, payment is made in accordance with the TIPster's arrangements. No contact is ever made with the TIPster, thereby insuring his anonymity.

Rewards are given only if the TIP leads to a conviction. A three-man committee determines the amount of the cash reward.

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Medical Careers

College freshmen are showing increased interest in medical and health careers, the American Council on Education reports. ACE surveys show 5.5% of 1972 freshmen said their probable career was physician or dentist, compared to 4.4% in 1971 and 3.7% in 1968. Nursing careers were indicated by 4.7%, compared to 4.1% in 1971 and 2.7% in 1968. Other health professions were preferred by 7.3% in 1972, compared to 4.1% in 1968.

Burn Dressings

Synthetic "skin" and fetal membranes have been found effective as dressings for burns, according to reports at the recent American College of Surgeons meeting. The synthetic skin is used to help remove bacteria and dead tissue

from the burn-wound surface, in preparation for skin grafting. The polyurethane-polyethylene material, one sixth of an inch thick, is treated with antibiotics to help control infection, University of Cincinnati physicians said.

Dr Martin C Robson of Yale University said fetal membranes proved to be effective biological dressings in animal studies.

The membranes, which encase the fetus before birth, are discarded daily in almost all hospitals and thus are available at no cost to the patient, he said. In the past, dressings have been obtained from human cadaver skin grafts or pig-skin. But those sources are not readily available in the general hospital and their use adds to "the already overwhelming cost to the burned patient," Dr Robson said.

Drug Abuse Director

Governor Mandel, as recommended by Dr Neil Solomon, has appointed L Robert Evans as Director of the Maryland Drug Abuse Administration.

Mr Evans, immediate past president of the Baltimore County Bar Association, has been Deputy State's Attorney for Baltimore County since 1967.

"We have in Mr Evans," Dr Solomon said, "a man of proven administrative capability of the sort that will be most useful in the management of these programs; furthermore, we expect, that with his legal background, he will be instrumental in the development of significant clarification of the civil commitment program of the Administration."

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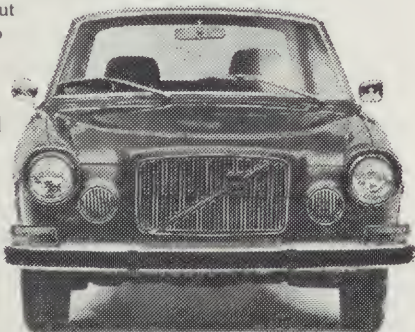
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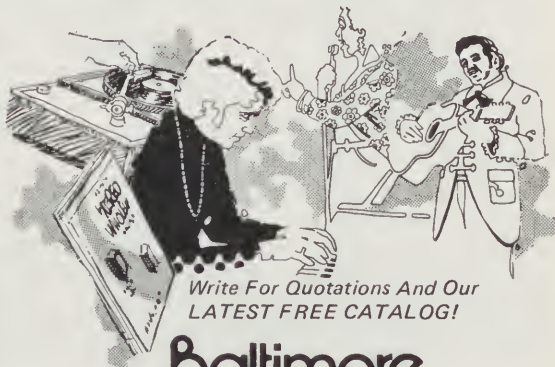
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Accidental Poisoning Ingestions

Annually a compilation of accidental poisoning ingestions in Baltimore City residents is made by the City Health Department's Bureau of Biostatistics from monthly reports from emergency rooms and pediatric clinics. While this report does not include persons seen by private physicians or those who treated themselves without consulting a physician, it does show some significant trends in the city's accidental poisonings.

For the first time in the past five years accidental poisonings reported from 22 Baltimore hospitals and clinics show a decrease. In 1972, 4,283 accidental poisoning cases were reported, a decrease of 101 when compared to 1971.

Internal medicines still lead the list of substances involved in poisoning accidents although a decrease of 90 has been noted. In 1971, there were 2,779 reported internal medicine poisonings compared with 2,689 in 1972. While aspirin remains the single internal medicine that causes most accidental poisonings, there were fewer aspirin poisoning cases reported for the third straight year. In 1972, a total of 342 aspirin poisonings was reported—59 fewer than in 1971. The decline in the number of accidental poisonings from internal medicine may be due to preventive steps taken over the last few years to promote and produce safer packaging and better family care of medicine.

Reported cases of both the second and third leading cause of poisonings also declined in 1972. Household preparations, the second leading cause (a group that includes washing and cleaning products, pesticides, cosmetics, polishes, paints, and solvents), fell 182 cases from 746 in 1971 to 564 in 1972. External medicines, the third leading cause, fell by 30 cases from 107 in 1971 to 77 in 1972.

In spite of a decrease in the overall total of reported accidental poisonings in Baltimore, drug abuse poisonings continued to rise. Last year, 1,883 persons were reported treated for

poisonings due to depressants, stimulants, narcotics, and psychopharmaceuticals. This is 169 cases more than were reported in 1971. There were, however, fewer deaths attributed to drug abuse in 1972. Of the total of 70 accidental poisoning deaths, 59 were drug-abuse deaths, 25 fewer than in 1971. This may be due in part to federal action in drying up narcotic supplies.

In previous years the 1-to-4 age group topped the list as the period when accidental poisoning was most likely to occur. However, in 1972, perhaps because of better parental awareness for protecting the preschool child plus some helpful packaging by manufacturers, accidental poisonings in this age group in Baltimore City has dropped to third place. On the other hand, the drug problem has raised accidental poisonings in persons 12 to 24 years old, the years of experimentation and addiction. Doubtless because some drug abusers are now aging with their addiction, the second highest age group at which poisonings occur is now age 25 years and over. Reported poisonings for those age 12 to 24 years rose from 1,477 in 1971 to 1,555 last year. For those 25 and over, the rise was even greater—from 1,154 cases in 1971 to 1,330 in 1972, up 176 cases. But in the 1-to-4 age group, accidental poisonings fell by 383 cases, from 1,395 in 1971 to 1,012 in 1972.

During National Poison Prevention Week, March 18-24, the Maryland Poison Prevention Committee conducted a variety of educational programs utilizing press, radio, TV, and the mass distribution of leaflets and posters to bring the accidental poisoning hazard to the attention of residents. This committee comprises representatives of the Maryland State Department of Health and Mental Hygiene, the Baltimore City Health Department, the Maryland Pharmaceutical Association, the Maryland Chapter of the Academy of Pediatrics, the Baltimore Safety Council, the Federal Food and Drug Administration, the Medical and Chirurgical Faculty of Maryland, and the Baltimore City Medical Society.



MRS FREDERICK MILTENBERGER
Ed'tor

woman's auxiliary

The Auxiliary Welcomes Its 24th President

Mrs Leslie R (Donna) Miles Jr, Lonaconing Md, was installed as President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland at the 24th Annual Meeting on April 26, 1973. Mrs Miles has been a member of the Alleghany County Auxiliary for 13 years, serving as President in 1970-71. She has been active on the State Board as well as in her county organization, serving as Health Education Chairman and as Membership Chairman.

Besides caring for her family and serving the Auxiliary, Mrs Miles has been involved with her community. Here, in her own words, is a brief capsule of her many and varied activities:

"My life as a potential Auxiliary member started in 1950 when I left my secretarial job at Jefferson Hospital in Philadelphia to marry Les, who at that time had just completed his freshman year at the University of Maryland. It is interesting to think back and remember that even then we had our own little social group of students' wives and thoroughly enjoyed our meetings.

"Seventeen years ago we moved to Lonaconing Md where Les started his practice as a GP. I soon found that a small town has more than enough to keep one busy, and managed to get involved in many activities both church and community oriented. As our children became older, the school activities and all the other things that children get involved in became a large part of my life—Den Mother, Scout leader, Sunday school teacher, etc.

"Our son Bruce is a Junior at West Virginia University and Donald is a Freshman at Marshall University in Huntington WVa. Our daughter Diana is in the sixth grade, and her activities are still keeping me stepping.

"I have been a member of the Alleghany County Auxiliary since the second year of its existence,



Mrs Leslie R Miles

13 years ago, and I was the President in 1970-71. That was my introduction to our State Board, and a very pleasant one. I have really enjoyed our meetings and knowing all the wonderful people who represent our Auxiliary at the State level.

"I enjoy bridge and golf and many other things when I find the time to spare. My other extra-curricular activity is the Girl Scouts. At the present time I am serving as the Field Vice President of the Shawnee Council, and that pretty well keeps the rest of my spare time occupied.

"Last fall Les was ordained to the priesthood in the Episcopal church, and is now the vicar of our small mission in Lonaconing. This, of

course, is a privilege for both of us, and I have added the job of vicar's wife to my list of activities.

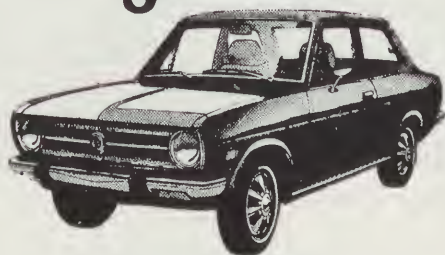
"I am really looking forward to a pleasant and fruitful year as the President of our State Auxiliary. It will be a challenge I'm sure, but with the help of an outstanding membership and an excellent Board it should be a great year."

MRS ROBERT A REITER
Editor, 1972-1973

Managing Editor's Note: Thanks to Mrs Reiter for yeoman service as Editor of this page for the past year and welcome to the new editor, Mrs Frederick Miltenberger! And, just to set the record straight, I can't claim relationship to the new Woman's Auxiliary President, although I'm also known as Les Miles (Lester H Miles).

A pacemaker, as most people know, is an electrical device implanted in a heart patient to regulate his heart beat. Now, Canadian physicians have devised a pacemaker to straighten the spine. It is designed to, hopefully, correct the curved spine condition known as scoliosis, which affects mainly young girls. The spinal pacemaker sends out impulses which put the muscles controlling the vertebrae into spasms, forcing them into normal alignment, said Dr Walter Bobechko of the Hospital for Sick Children in Toronto. The device has been tested successfully in animals.

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executive director's newsletter

June 1973

ANNUAL MEETING REGISTRATION

The 1973 Annual Meeting registration topped an all-time record when over 2,100 persons registered as being in attendance. Of this 2,100 over 1,200 were physician members of the Faculty. Students and other health personnel totaled 900.

Exhibitors this year expressed pleasure at the high interest evidenced at the technical and scientific exhibits.

WE NEED APRIL 1972 JOURNALS

If you have a copy of the April 1972 issue of the Maryland State Medical Journal and don't need it any longer, we'd be glad to take it off your hands. Repeated requests for duplicates of this particular issue have exhausted our supply of extra copies. Just let us know, or drop it in the mail to us. Many thanks.

LEGISLATIVE ITEMS OF INTEREST

The final issue of The Assemblyman covering actions of the 1973 General Assembly has recently been mailed to all members and other interested parties. Items of particular interest for physicians to note include:

The establishment of a Commission on Hereditary Disorders; this same law abolished the legal requirement for PKU testing of newborns.

Establishing the right of the Secretary of Health and Mental Hygiene, on request of any area in the state, or on his own initiative, to investigate need for medical services in that area and to contract for such services if needed.

Change in the number of professionals from five to four in order to use a professional corporation name not containing the names of the professionals.

Requiring the Department of Health and Mental Hygiene, in cooperation with the Faculty, to define disorders affecting drivers; and requiring reporting of such individuals to the Motor Vehicle Administration.

Requiring physicians who perform clinical laboratory tests in their offices on or for their own patients to

demonstrate proficiency in such performance. Jurisdiction would be within the Division of Laboratories, Department of Health and Mental Hygiene.

A budget amendment also provided for designation of an Assistant Secretary of Health and Mental Hygiene to administer the Medicaid program within the Department. Such appointment has not yet been made.

DRUG SUBSTITUTION

The Department of Health and Mental Hygiene has developed a list of drugs considered to be clinically equivalent and attested to by the US Food and Drug Administration. These drugs may now be substituted by pharmacists for any prescription ordered or written by a physician for such antibiotics, UNLESS THE PHYSICIAN DIRECTS OTHERWISE.

On his Rx blank, the physician may state NO SUBSTITUTION; initial such a printed statement; or check a box indicating no substitution.

Pharmacists are required to notify the physician in writing that a substitution has been made and the name of the drug substituted. They are also required to pass on the savings (if any) to the patient.

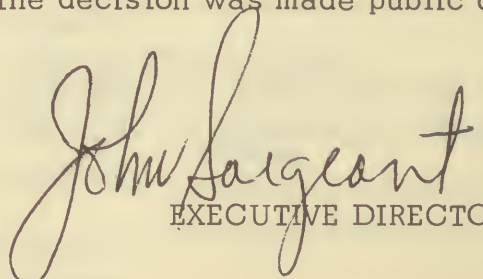
If you wish further information or details, please contact the Faculty office.

MARP PROGRESSES

The Maryland Foundation for Health Care's MARP (Maryland Admission Review Program) becomes operational on June 1, gradually expanding until all hospitals in the state will be participating by October 1. Speakers are available to component societies, hospital medical staffs, and others regarding details of the program, which is receiving nationwide attention.

CLAIM DISMISSED

The celebrated "Brecher" case wherein a physician was ordered to pay the hospital costs of a patient's hospitalization has been overturned by the courts in Pennsylvania. The decision was made public on April 19.


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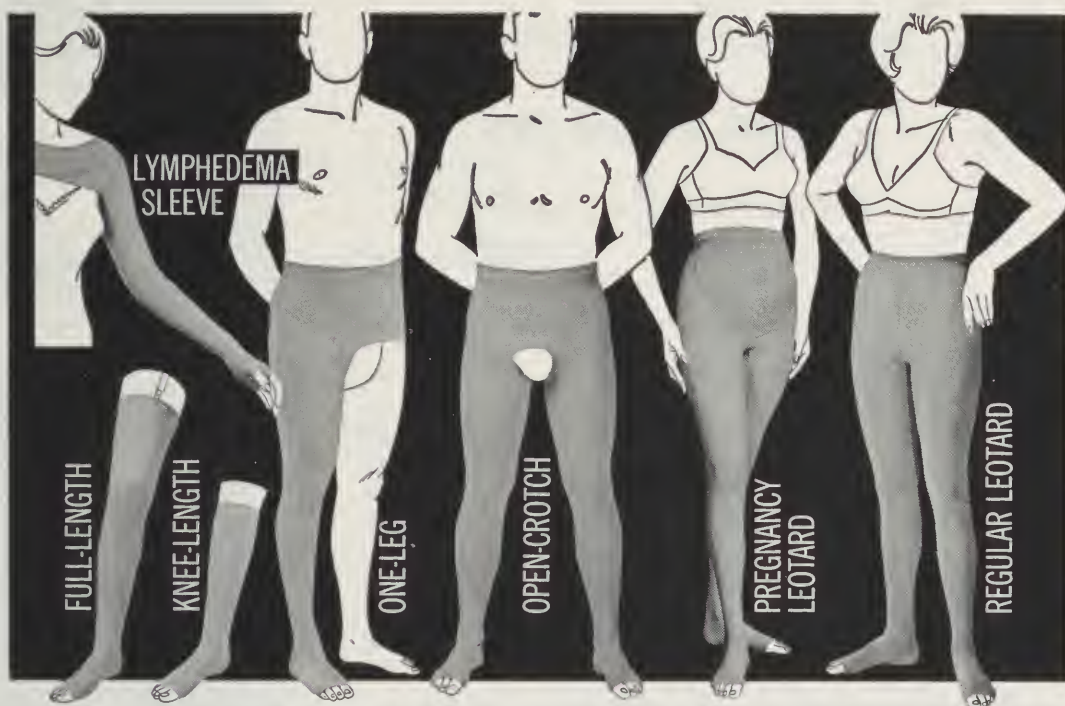
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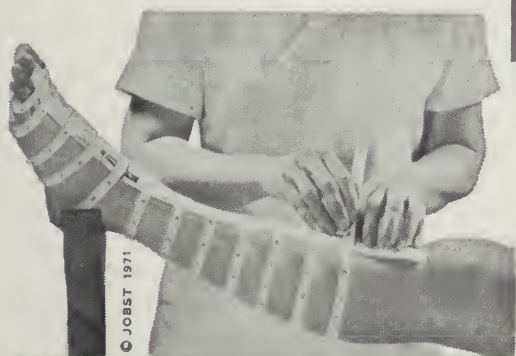
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RAYMOND L MARKLEY MD
Chairman

MRS FRANCIS C MAYLE
Editor

INTRODUCING DR FRANCIS C MAYLE

Francis C Mayle MD is the new Chairman of the Maryland Medical Political Action Committee. Raymond L Markley MD, the former chairman, completed his term of office recently. Dr Mayle served as Vice Chairman in 1972.

A medical neurologist whose office is in Bethesda, Dr Mayle is a graduate of Georgetown University where he was awarded his BS in 1949, his MD in 1953, and an MS in neurophysiology in 1959. He served his internship in the US Navy and, after completing his obligation to the Navy, returned to Georgetown for his residency in neurology. He has been an Assistant Clinical Professor at Georgetown since 1959. The doctor was certified by the American Board of Neurology in 1962.

Dr Mayle is a member of the staff of Suburban Hospital, Holy Cross Hospital, Washington Adventist Hospital, and Montgomery General Hospital in Maryland. In the District of Columbia he is a staff member at Providence, Georgetown University, Children's, and Sibley hospitals. He has served on numerous hospital committees and is presently chairman of the Utilization Review Committee at Holy Cross Hospital.

Currently vice president of the Montgomery County Medical Society, Dr Mayle has been chairman of a number of committees of the Society including Mental Health and Professional Mental Relations. He is also chairman of the Liaison Committee between the Society and the Montgomery County Bar Association. In 1960 he was appointed by the Montgomery County Council as a member of the Advisory Committee to the Public Health Officer.

A past president of the Georgetown Clinical Society, the doctor is also a member of the AMA, the American Epilepsy Association, the St Luke's Society, the Southern Medical Association, the Washington Medical and Surgical Society, and the American Geriatric Society. He has been a Fellow of the American College of Physicians since 1968. An active member of the American Academy of Neurology since 1962, he was named a Fellow in 1972 and is finishing a four-year term as chairman of that group's Press and Public Relations Committee. He is an associate member of the District of Columbia Medical Society.

Since 1968 Dr Mayle has been Chairman of the Metropolitan Washington Regional Medical Program. He is a



Dr Mayle

Deputy Assistant Medical Examiner for Maryland and a consultant to the Department of Motor Vehicles Medical Advisory Board.

The Mayles have two boys and two girls ranging in age from 18 to 13.

The doctor was a member of the Board of Governors of Georgetown University from 1964 to 1967 and is currently a member of the Alumni Senate. He is a member of the Knights of Columbus and has held offices in the past.

Dr Mayle is a member of the Church of the Little Flower, where he is a regular usher, and has served on the Parish Council. When he can find the time, the doctor enjoys working in both his garden and his window greenhouse and reading for relaxation. He also enjoys his tanks of tropical fish.



Baltimore City Medical Society

Drug Use and Abuse

DONALD M PACHUTA MD
Editor

WHAT IS DRUG ABUSE? THE VIEW OF A PHARMACOLOGIST

DR DAVID A BLAKE

Dr Blake is Associate Professor and Chairman, University of Maryland School of Pharmacy, Department of Pharmacology, Baltimore Md 21201.

Editor's note: This is the second article in a series about concepts of drug use and abuse and different approaches to the problem.

Because the phenomenon of "drug abuse" is multi-faceted, it is unsatisfactory to discuss it from a single perspective. However, one is usually reluctant to transgress into disciplines other than those in which he is labeled competent. Consequently, considerable confusion and difficulty in communication regarding this subject exists within the professions and also between the professions and the general public. Having been given the opportunity of defining "drug abuse" for the readership of this journal, I shall attempt to use a holistic treatment that is practical and hopefully theoretically sound.

Because drugs are inanimate objects, they do not possess qualities that can be labeled good or bad. Drugs are molecules or mixtures of molecules which can be used in an infinite number of situations that could be labeled good or bad. I suppose that the term "drug abuse" conveys the idea that the drug is being used in a bad situation or for bad reasons. A similar meaning is conveyed by the term "drug misuse." In either case, the important question is to define what is the bad or inappropriate use of a given drug.

From the pharmacological point of view it is axiomatic that the use of the drug is improper, inappropriate, or bad when the expected therapeutic benefit from the drug is outweighed by the inherent potential hazard associated with its use. In its most fundamental pharmacologic terms, the benefit-to-hazard ratio can be described by the "margin of safety" or the ratio of effective

dose to toxic dose.

A pharmacologist would argue that use of a potent antileukemic agent with a narrow margin of safety is proper and appropriate whereas the use of antihistamine compounds with relatively wide margins of safety in cold remedies is inappropriate because of the differences in the conditions for which these drugs are intended. (There seems to be little acceptable clinical evidence of any efficacy of antihistamine compounds in the treatment of symptoms of upper respiratory tract disease.) In these two examples, it is relatively easy to define the intended therapeutic effect; however, this is usually not the case in the contemporary self-administration of drugs in the nonmedical setting. In the majority of situations labeled drug abuse, the drug involved is a psychoactive compound and thus the effects as well as the benefits are difficult to describe or measure. In addition, the voluntary self-administration of psychoactive drugs may be encouraged by emotional and environmental factors—unidentifiable, but nevertheless quite real.

There is no doubt that growing numbers of persons, both young and old, are self-medicating with a variety of chemicals, both licit and illicit, in an attempt to escape the dysphoria associated with anxiety and depression. Although this practice cannot be condoned, neither can it be labeled totally inappropriate from a pharmacologic point of view. A significant case could be made in support of limited self-medication for such conditions in the absence of adequate delivery of mental health services in our society. Moreover, it is likely that a person complaining to a physician of anxiety and depression would be placed on therapy with little or no counseling or psychotherapy.

Another major reason for self-administration of psychoactive drugs appears to be for the pur-

pose of social facilitation. Either peer group pressure or the desire to achieve friendships and acceptance has prompted many young persons to use stimulants, depressants, and psychedelic agents. Marijuana seems to have become the social drug of choice for at least 10% of our population. The proponents of "grass" as a substitute for alcoholic beverages have extolled the virtues of this botanical *ad nauseum*.

With regard to the social use of intoxicants, it is exceedingly difficult to envision a benefit-to-risk ratio. The universal popularity of alcoholic beverages at social gatherings and other recreational activities suggests that important benefits are derived from their ingestion. However, alcohol dependence is a very large and growing problem in our society, having caused untold family disruption, economic loss, and disease. Consequently, it seems appropriate to apply parallel reasoning to alternative forms of social drug use. Thus, marijuana used in moderation at subintoxicating doses and without impairment of mental or physical well being and without disruption of interpersonal and occupational relationships is not an abuse of the drug.

A third form of contemporary nonmedical use of psychoactive drugs is related to the attempt to achieve a mystical or religious experience. The fading popularity of this practice is testimony to the lack of efficacy and number of side effects of LSD and similar drugs when used in this manner. The so-called psychedelic or "peaking" experience can be indescribably good but can also be terrifying. There is little evidence that the psychedelic experience is reliably achieved in a rewarding fashion in the uncontrolled setting. On the contrary, there is excellent evidence of the adjunctive value of the LSD-induced psychedelic experience in psychotherapy and the management of the terminal cancer patient. The evidence for efficacy is less compelling in the treatment of the alcoholic or the drug addict, although preliminary results are encouraging. Thus, without proper supervision and controls, the risks far outweigh the potential benefits of psychedelic drug use for mystical or religious purposes and thus is properly termed drug abuse.

The fourth type of contemporary nonmedical drug use is by far the most hazardous and least defensible. Some have called it experimentation or thrill-seeking but I prefer to view it as a form of cerebral masturbation. Any drug (in fact combinations are usually employed) that can jolt the central nervous system or produce a state of mental clouding or dreamy euphoria has been and is being employed by a growing segment of the youth population. It is least defensible

since the potential benefit to the user is evanescent and often followed by a period of extreme fatigue or dysphoria. Moreover, the majority of "ODs," "bad trips," and "freak outs" occur with this manner of drug use.

The application of the term drug abuse to all cases of illicit drug use is inappropriate and unfortunate. The use of illicit drugs is not equivalent to abuse of these drugs. The use of illicit drugs may properly be regarded as abuse of the laws and social customs that have been responsible for designating specific drugs as legal or illegal which are in part based on the existence of approved medical or social uses. This is the point of departure of pharmacologic rationale for such decisions, as there are numerous specific instances of double standards or hypocrisy (eg, aspirin is teratogenic in rats in pharmacologic doses whereas marijuana does not appear to be an embryopathic substance in this or other animal species). An additional problem is the common practice of designating every use of a given drug as abuse or misuse rather than attempting to distinguish between those uses of a particular drug which are rational and those which are not (eg, the use of aspirin as a headache remedy versus its use as a hypnotic).

As mentioned, a significant portion of the population currently considered to be drug abusers are employing drugs as a final desperate attempt to resolve problems which have been unresolved by family, community, the helping professions, and our society in general. This being the case, the blame seems misplaced when directed totally at the individual involved. This is not offered as an excuse, or rationale for nonmedical drug use, but rather to focus on the ultimate cause of self-abusive use of drugs in the hope of encouraging a more understanding and compassionate attitude towards the problems underlying drug abuse. As a priest friend of mine once observed; "There but for the grace of God go I."

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RHEUMATIC FEVER, 2nd edition, by Milton Markowitz MD, and Leon Gordis MD MPH, WB Saunders Co, Philadelphia, 1972.

This is Volume II in the series, Major Problems in Clinical Pediatrics. Many physicians in Maryland will recognize Dr Markowitz as a former pediatrician who practiced in Baltimore, and Dr Gordis as an associate with the Maryland RMP.

This monograph reviews the diagnosis, management, and prevention of rheumatic fever and rheumatic heart disease in the light of new knowledge of the biologic and social aspects of these conditions. We strongly recommend the purchase of this book to those who have any connection with these conditions in their practice.

CURRENT DIAGNOSIS AND TREATMENT, by Marcus A Krupp MD and Milton J Chatton MD, Lange Medical Publications, Los Altos Calif, 1973.

This book, while coauthored by the physicians, also has a list of distinguished contributors, experts in their field.

It has been published annually since 1962; the authors state that it will be a biennial publication starting this year. Evidence that it meets the need of the practicing physician is indicated by its continued publication in an expanded format and ready reference manner. Heavy emphasis is placed on the medical treatment of various body conditions with drug dosages that "are in agreement with current official pharmacologic standards and responsible medical literature."

It is not a textbook of medicine but is a useful desk reference on widely accepted techniques currently available for diagnosis and treatment.

RISKS IN THE PRACTICE OF MODERN OBSTETRICS, by Silvio Aladjem MD, C V Mosby Co, St Louis, 1972.

The thrust of this book is to emphasize "total patient management" and the Obstetrician's role in this management. Its implication is that the obstetrician must know the effect of disease on pregnancy and pregnancy on disease just as much as the internist does. Only in this way, the author argues, does the obstetrician cease being a technician for delivery of the baby and become a part of the whole management team.

The author then goes on to state: "If the obstetric specialist of the future must have an in-depth knowledge of so many aspects of the high-risk mother and fetus, a logical question follows: Can he do this and still know general gynecology, oncology, and endocrinology, all also in depth?" He answers in the negative.

In support of this argument, the author states that "the development of training programs for a subspecialist in maternal and fetal medicine is under active consideration by both the American College of Obstetricians and Gynecologists and the American Board of Obstetrics and Gynecology." The book discusses in depth many of the risks inherent to both mother and fetus when a pregnancy is undertaken.

It is a compendium of articles outlining these high risks and is enhanced by its list of outstanding contributors from throughout the free world.

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**by John Sargeant,
Executive Director**

The Council met on Thursday, March 29, 1973 and took the following actions:

1. Agreed to waive 1973 dues for various members on account of illness and on recommendation of their respective component medical societies.
2. Agreed to recommend Emeritus Membership to the House of Delegates for various members who are no longer engaged in the active practice of medicine, again on recommendation of respective component medical societies.
3. Renewed the Executive Director's contract for an additional three-year term on the same basis as previous contracts.
4. Agreed to no longer pursue the question of a class-action suit against Blue Shield and the Social Security Administration because of the discriminatory manner in which fees have been paid under Medicare. This action was taken because of the tremendous financial cost involved in pursuing such a class-action suit.
5. Approved an appropriation of \$1,000 from the educational fund to serve as "seed money" in connection with a TV series that would be aired over a local TV station. Appropriate credit would be given the Faculty and the series would be educational in various health fields.
6. Reaffirmed support of the Maryland Medical Political Action Committee—its concept and its activities.
7. Adopted the following amended protocol in connection with the employment of Nurse-Midwives:

The certified nurse-midwife may also be employed in the State of Maryland in a licensed acute general hospital with a maternity department, certified outpatient facility, and/or group practice in collaboration with a physician licensed in Maryland to practice medicine and surgery and actively practicing obstetrics.

8. Adopted the following motion in connection with the Governor's Executive Order on a State-wide Emergency Medical System:

The Council supports the concept of a statewide emergency medical system as defined in the Governor's Executive Order and will cooperate towards the implementation of such a system. The Faculty stands ready to assist in the selection of the Director of the Division of Emergency Medical Services in the Department of Health and Mental Hygiene; as well as to assist in the selection of the Director of the Institute for Emergency Medicine. It is urged that these two positions be occupied by different persons.
9. Authorized the Chairman of the Committee on Emergency Medical Services to meet with the Governor and convey this information to him.
10. Referred a communication from Montgomery County Medical Society to the same Committee for study and response to that component. The letter stated that all persons injured should be first triaged at local community hospitals for determination as to the need for evacuation to more skilled facilities elsewhere.
11. Endorsed the candidacy of Helen B Taussig MD, Baltimore, for the Sheen Award (a \$10,000 grant), the selection of which is made by the AMA Board of Trustees.

12. Heard that the Subcommittee on Maternal Welfare is preparing Guidelines for Physicians in the Performance of Therapeutic Abortions, dependent on the status of state legislation in this regard. A report will be made to a later Council session.
 13. Authorized Faculty guarantee of a rental lease signed by the Maryland Foundation for Health Care.
 14. Approved the following resolution for introduction by the Council to the House of Delegates:

Resolved, That the membership of this society be informed that the Medical and Chirurgical Faculty has taken no official stand to date on PSRO as embodied in HR 1 (the Bennett amendment); and

Resolved, That in the ensuing months every effort of our society and its members be expended to acquaint themselves with the law and its (as yet unpublished) regulations so that an informed decision may be made at the appropriate time.
 15. Approved unanimously the following motion:

Physicians who provide underwriting information to Blue Cross and Blue Shield on patients of physicians should be compensated for providing this service as do other insurance underwriters. Compensation should be on the basis of the Usual, Customary and Reasonable fees, dependent on the data provided.
-

The Executive Committee met on Thursday, April 12, 1973 and took the following actions:

1. Discussed in some detail the contractual arrangements proposed by the Department of Health and Mental Hygiene for obstetrical deliveries in a specified area of the State, and agreed to pursue this question further with the to-be-named Assistant Secretary for Medicaid in the Department of Health and Mental Hygiene. The Executive Committee also agreed to discuss other fees paid under the Medicaid program, as well as to review the statement appearing on the MS-4 Medicaid form with the new Assistant Secretary.
2. Approved a revised employees pension plan that would: a) have no decrease in employee benefits, b) make various modifications to bring the plan into line with IRS requirements, c) include two employees not now eligible under the current plan, d) provide for employee vesting at the rate of 10% per year, e) permit inclusion of component society and wholly owned organizations of the Faculty if such groups wish to pay for such coverage, and f) provide a broader range of employee benefits.
3. Approved in principle a proposed application by the University of Maryland School of Medicine for an HEW grant for a study to determine specifications and guidelines for an effective continuing education program. It is understood that full details will be provided when the grant application is completed.
4. Determined that a case involving peer review would have to be settled through existing peer review mechanisms of the Faculty.
5. Amended present policy of payment for expenses of AMA Alternate Delegates attending AMA House of Delegates sessions so that no payment be made during the last term of office of an alternate delegate except when moving up to become a full delegate.
6. Agreed to recommend the name of Perry Hookman MD, of Cheverly, to serve as Faculty representative on the Howard University Physicians Assistant Advisory Board.
7. The following nominees are to be submitted to the Governor for appointments as indicated:

Advisory Council on Hospital Construction:

Marcus W Moore MD, Baltimore (reappointment)
William A Pillsbury MD, Timonium
John F Schaefer MD, Catonsville

Physical Therapy Board:

H Alvan Jones MD, Baltimore (reappointment)
Karl F Mech MD, Baltimore
William H Pillsbury MD, Timonium

Commission on Aging:

Emerson C Walden MD, Baltimore (reappointment)
Aubrey D Richardson MD, Baltimore
William Reichel MD, Baltimore

8. The Executive Committee adopted the following policy position with respect to acupuncture: "Acupuncture is the practice of medicine when used 1) for anesthesia; 2) for the relief of chronic pain, or 3) for the modification of organ function. Very little is known of the effects, intended or unintended, of acupuncture on modification of organ function. Since acupuncture is still investigational, it should be used by licensed physicians only and cannot be delegated to other persons."
9. Declined to respond to a hypothetical question raised by a physician in connection with hospital privileges. The physician is to be asked for specific details when and if such a situation as hypothesized does occur, when an answer can be given.
10. Authorized submission of the following list to the Governor in the event a vacancy occurs on the Occupational Disease Board:

John F Schaefer MD, Catonsville
William A Pillsbury MD, Timonium
William J McClafferty MD, Baltimore
11. Approved loan of the Archer diploma to the Maryland Historical Society for a special display lasting about six weeks, subject to usual precautions with respect to security, insurance, and identification as to ownership.
12. Approved submission of the following list of names for appointment to the newly created Maryland Commission on Hereditary Disorders:

Victor McKusick MD, Baltimore
Carroll Spurling MD, Baltimore
DeWitt E DeLawter MD, Bethesda
13. On legislative matters, heard that SB933, which would have expanded the jurisdiction of the Health Services Cost Review Commission to include private practice physicians charges, had been defeated; and also authorized a request to the Governor for veto of SB828, dealing with publication of average payments made by insurance carriers to health providers; and veto of SB614, mandating Blue Shield to pay for Chiropractic services.



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The Physician/Patient Relations Committee met on Tuesday, March 27, 1973 and took the following action:

1. Added a new paragraph to the protocol dealing with antidiscrimination rulings so that the policy statement now reads:

(CAPS INDICATES SECTION ADDED)

Discrimination

"The Medical and Chirurgical Faculty endorses the concept adopted by the AMA's Judicial Council in respect to treatment of patients in emergencies, which is as follows:

"A physician should respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service.

"However, in addition, the Medical and Chirurgical Faculty respects the right of the physician to choose whom he will serve. It strongly deplores, nevertheless, such right being exercised, based on race, color, religion, or creed." (Adopted Oct 29, 1969)

"THE MEDICAL AND CHIRURGICAL FACULTY ALSO STRONGLY DEPLORES THE RIGHT OF SELECTION OF PATIENT BASED UPON A CLASS OF PATIENTS . . . THAT IS, THOSE INDIVIDUALS WHO ARE MEDICARE OR MEDICAID RECIPIENTS. IT IS RECOGNIZED THAT ANY INDIVIDUAL IN A CLASS OR CATEGORY OF PATIENTS MIGHT NOT BE ACCEPTABLE AS PATIENTS TO THE PHYSICIAN. HOWEVER, IT IS NOT APPROPRIATE TO CATEGORIZE ALL SUCH PATIENTS AND TO DENY THEM CARE AS A GROUP BECAUSE OF THE SHORTCOMINGS OF INDIVIDUALS WITHIN SUCH A GROUP."

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The hospital complex is composed of the main hospital building, the Helene Fuld School of Nursing, and several outreach programs. The outpatient and emergency departments have been merged into an ambulatory patient care facility capable of functioning on a 24-hour-day, 7-day-week basis. Provident proudly lays claim to being the first all-electric hospital in the country. It is a new facility brought to fruition by multi-racial teamwork and is fast becoming an integral part of the community it serves.

Recent significant developments at Provident include appointment of full-time chiefs in the departments of Medicine, Surgery, Pediatrics, Ob-Gyn, and Psychiatry. The departments of Radiology, Pathology, and Anesthesiology are also

headed by full-time chiefs. The affiliation with the University of Maryland has been strengthened. All clinical chiefs have faculty appointments at the University of Maryland School of Medicine.

Community outreach programs have been sponsored by the hospital to deliver comprehensive health care, mental health services, alcoholism treatment services, drug abuse prevention, and sickle cell screening and education services to the population living in the immediate hospital area.

In preparation of this report, C Alex Alexander MD, DrPH, Director of Medical Affairs, while acknowledging the importance of the historical evolution of the institution, placed strong emphasis on the increasing commitment of Provident to shape the hospital into an island of medical excellence in the inner city of Baltimore.

This spirit of commitment and involvement was also stressed by Archie Robinson Jr MD, President of the Medical Staff, in his recent report enumerating the goals for Provident.

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- Carotid Sinus in Hypertension
- Cardiac Surgery in Children with Rheumatic Heart Disease
- Infarction in the Younger Patient

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Scientific sessions will be scheduled early in the day to allow free time for shopping and sightseeing.

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Committee on Programs and Arrangements

Med-Chi, 1211 Cathedral St, Baltimore Md 21201

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SEPT 15

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SEPT 19

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SEPT 19-23

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SEPT 23

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MED-CHI HAS HAD MANY HOMES

This article, written by free-lance writer Jeanne B Sargeant, and augmented by historical photo and map coverage by the Journal staff, was suggested by Dr DeWitt E DeLawter, now Immediate Past President of the Faculty, as being appropriate for the 175th year of the Medical and Chirurgical Faculty of the State of Maryland. It should also serve as a good reference source for those who have the job of planning for the 200th Anniversary observance in 1999!

Although it may seem as if the Medical and Chirurgical Faculty has been stationary at 1211 Cathedral St in Baltimore City since its inception in 1799, this is a fallacy. Actually the physicians and surgeons of Maryland proved a particularly peripatetic lot in the nineteenth century. From 1857 until 1909, they shuffled about with their medical satchels and their slowly growing library collection making a steady succession of moves until they finally were shepherded into their own headquarters building under the commanding aegis of Dr William Osler, later Sir William.

Little could they guess during their eight worrisome moves that some 64 years later they would be casting about again for more commodious quarters. Even in 1961 when 1211 Cathedral St was renovated at a cost of some \$350,000, there was no thought that a little over a decade later consideration would be given to a new home outside Baltimore City. Yet Med-Chi is now the owner of 20 acres of land at the conjunction of Routes 29, 40, 70-N and Rogers Ave in Howard County where a new headquarters complex may be constructed near the proposed Bon Secours Hospital from whom the property was acquired. Purchase of the acreage ran to \$200,000 in a location where property values are certain to rise.

The saga of the Faculty's various moves in and out of narrow little houses, dark and gloomy halls, and sundry unsatisfactory accommodations starts in 1857 when, as John C French relates in his brief history of the Medical and Chirurgical Faculty published in conjunction with the Faculty's sesquicentennial in 1949, a "drooping society" cast about for its first home. This fraternity of practitioners picked a dwelling house at 47 North Calvert St to house its library of some 1,200 books and provide space for its "conversational meetings." The property was acquired by arranging an even exchange of bank stock worth nearly \$35,000 and in return taking title to a house 25 ft wide, of two stories and an attic, with nine rooms in all. This was subject to a redeemable ground rent of \$150 a year.

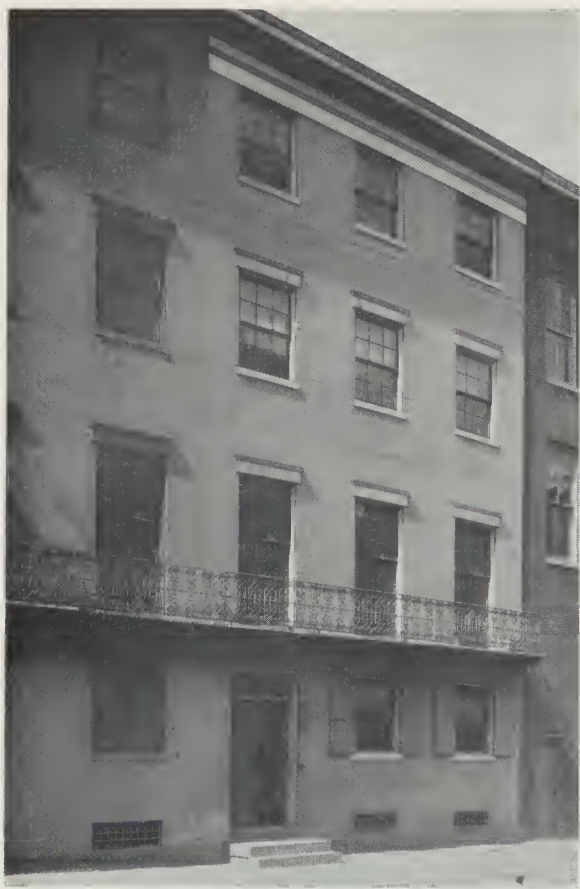
An executive committee headed by Dr John



FIRST HOME, 1858-1867, 47 N Calvert St, owned.

Francis Monmonier raised subscriptions and was able to alter the building to provide a second floor back room as a library with the front room on the same floor serving as an assembly hall. The first floor rooms were equipped so that they could be rented to lodges for \$160 annually while the hall, when not used by the Faculty, brought in an additional \$175 for its use by the local Medical and Chirurgical Society and the Maryland College of Pharmacy. Thus it was that on June 2, 1858 the members assembled for the first time under what could be called their own roof.

This skinny little house met the Faculty's needs for just over a decade. By 1867 the members found that the growing business of the Port of Baltimore had greatly increased traffic on Calvert St, making them anxious for a less noisy locality for their meetings. Accordingly, in the fall of 1867 they sold their hall and bought in its stead a house at 60 Courtland St for \$5,700 with a ground rent of \$138. This Courtland St building, though three stories high, was narrower and less roomy than their first home and proved a bad investment. In addition, it was situated on a steep slope running from Calvert St to Charles which was almost insurmountable in winter.



SECOND HOME, 1867-1874, 60 Courtland St, owned. (No photos available of third home, 1874-1877, Fayette St near Park Ave, rented; and fourth home, 1877-1878, Park and Fayette streets, rented.)

Unfortunately, disposing of the Courtland St property proved difficult for, when it was offered at a price commensurate with its cost, there were no buyers. Finally, in 1880 it had to be sold at auction with a net return of about \$500 which was less than 10% of its cost to the doctors 13 years before.

In the meantime, quarters were rented on the second floor of a house on the north side of Fayette St, a few doors west of Park Ave for a rental of only \$130 annually. Once again, despite the low rental, it was an unsatisfactory location so that in 1877 a move was made to two adjoining rooms on the second floor of a building on the northwest corner of Park and Fayette streets. In the space of just one year, again the physicians' real estate acumen proved poor and the movers carried the books and papers and meager office furniture to 122 West Fayette St, almost across from the room occupied in 1874. If these moves seem circuitous now they must have proved even more labyrinth-like to the constantly moving doctors then.

There was more to come, but at least the move to Fayette St yielded a more manageable rental fee for, by subletting its facilities to three local medical societies, the Faculty was able to reduce its annual rental of \$450 by some \$300.

During this period, when a chronic state of claustrophobia was engendered by lack of space, the recently established Johns Hopkins University proved a host in need for the use of Hopkins Hall on the new campus was made available to the Faculty for annual, well-attended scientific sessions. However by 1885, the activities at the young university had so increased that this meeting space was not always available. It became necessary to rent assembly space for the annual meeting from the Maryland Historical Society in the Athenaeum Building at the northwest corner of St Paul and Saratoga streets. As the members reveled in the additional space during this session, they were so impressed with the facilities that they proceeded to rent the entire ground floor of what had been the Mercantile Library to serve as a meeting room and library. This lease became effective in January 1886 at \$600 a year, and again other societies became sub-tenants to the profit of the Faculty.

These quarters served until 1895 although the membership was polarized over the accommodations, some describing the facilities as ample and



FIFTH HOME, 1878-1885, 122 W Fayette St, rented.

others depicting them as "dark and gloomy." By March 1895, a stormy session brought the matter to a crux and it was on the move again for the Faculty: the vote was to purchase still another piece of real estate, this time a building at 847 North Eutaw St for which \$10,000 in fee was paid.

The new hall was an ample three-story brick building near the upper end of the long block of North Eutaw St known as Hamilton Terrace. A housewarming was held Jan 11, 1896, but the cakes were hardly stale before it was decided changes had to be made. Old buildings located at the end of the lot were demolished and a two-story structure was built which extended from the main house to Linden St. This new addition cost \$3,500 which was subscribed "in a few minutes" and provided a first story containing a kitchen and a banquet room, with the upper floor accommodating an assembly hall where between three and four hundred could be seated.

It seemed the medical profession was becoming the patron saint of the building trade, however, for hardly had the Faculty settled in these more commodious quarters when Dr William Osler, of Hopkins Hospital fame, moved that the debt on the North Eutaw building be paid off and a new building fund be created to provide "suitable quarters for the profession of a city of 500,000 inhabitants." His proposal was deferred to 1908, however, and the Faculty celebrated its centennial in 1899 at the North Eutaw location, additionally making use of the main floor of the new McCoy Hall at the Hopkins for public meetings and exhibits.

Dr Osler's proposal was not tabled, however,



SEVENTH HOME, 1896-1909, 847 N Eutaw St, owned.

and in 1908 the trustees were able to report that a desirable building lot on Cathedral St had been obtained at a total cost of \$24,095.60 in fee. With their report, the trustees expressed the hope that one year hence they could point with "excusable pride to a modern edifice, owned and controlled by the ancient and honorable Faculty."

Point with pride they did indeed in exactly one year for on May 13, 1909 the handsome new building at 1211 Cathedral St was dedicated. The assembly room in the new structure was named Osler Hall in honor of the physician who had so vigorously promoted the move and who had shown unfailing devotion to the library which was finally to find gracious repose in the new building. Dr Osler had left Baltimore in 1905 to become regius professor of medicine at Oxford University as well as to acquire knighthood, but he was invited back to deliver the oration of the year in the hall named for him.

The Faculty stopped its perambulations and has remained in this building even though such architectural landmarks as the old Bryn Mawr School (later the Deutsches Haus) and even the B&O railroad station have either fallen to the wrecking ball or changed the complexion of the immediate environs.



SIXTH HOME, 1885-1896, St Paul and Saratoga streets, rented.

In 1961 the Faculty spent some \$350,000 on renovation of its quarters although it still presents almost the identical exterior appearance it did when James Cardinal Gibbons and those eminent physicians (Cushing, Welch, and Osler), were the principal dedication speakers. Two properties owned by the Faculty at 1215 and 1217 Cathedral St were razed and the space converted for parking off Maryland Ave. But the outer confines of the building have remained substantially the same. These confines, however, have become extremely confining for a society which today numbers over 4,000 members and is into politico-financial involvements which never could have been conceived even in 1961.

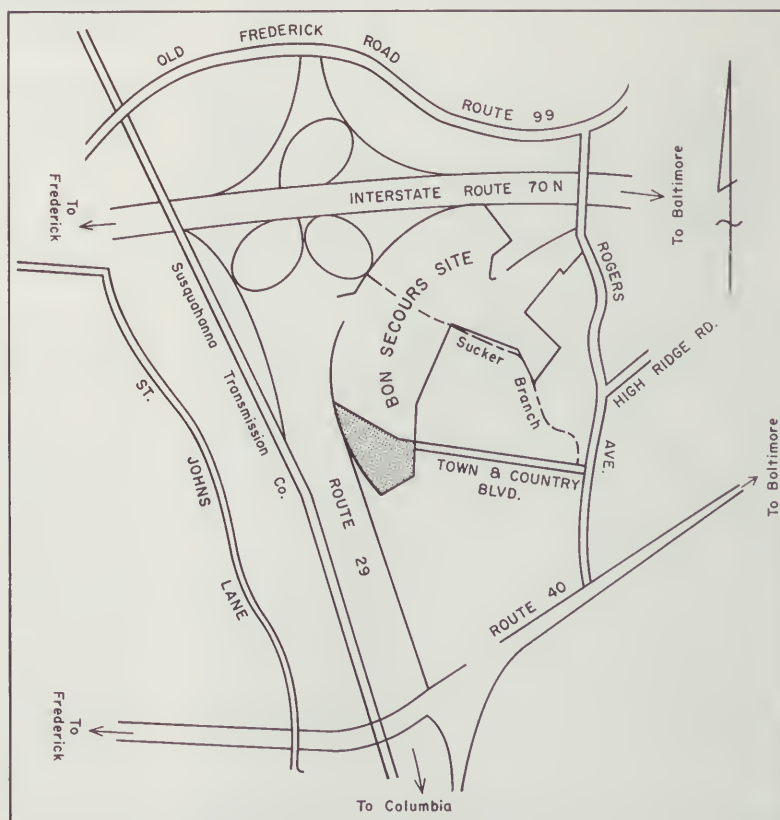
The purchase of the 20 acres in Howard County represents a move to give the Faculty lebensraum. Whether or not the Faculty ever builds there will depend on a determination of whether the state's medical society must abandon Baltimore City to find the room it needs. Or whether it will stick with the city and its problems because this is where it's always been at, as they say in Baltimorese.



EIGHTH HOME, 1909-?, 1211 Cathedral St, owned (Dedicatory photo).



NINTH HOME? This map plots the exact location of the 20 acres purchased by the Faculty in 1973. It is the dotted lower section of the "Bon Secours Site," near Ellicott City and about 20 miles from downtown Baltimore.



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THE RIGHT TO DIE

J ROY GUYTHER MD

Dr Guyther is Associate Professor, Family Practice Program, University of Maryland School of Medicine, Baltimore.

This paper was prepared for presentation at the Maryland State Bar Association Mid-Year Meeting, Baltimore, Jan 5 1973.

Information and reprint requests to Dr Guyther at the University of Maryland School of Medicine, Lombard and Greene streets, Baltimore Md 21201.

Former President Truman Dies at 88!

When you saw these headlines, I am sure there was no great surprise. Former President Truman had been dying daily for three weeks. Did he have a right to die with dignity; or was it necessary to keep him alive with respirators, oxygen, and intravenous fluids because he had been the President? Would the same efforts have been made to keep an old man alive who had been brought to University Hospital from down on the Block? Was the \$10,000 spent to provide medical care to keep ex-President Truman alive three weeks justifiable? These are the questions that are being asked today.

Recently, I received a letter from one of my patients, an 83-year-old lady with cancer that has invaded her spine causing considerable pain. She writes: "I was seized with one of those spasms of the back, running over to my shoulder and but for the pills you ordered I'd have gone out of my mind. Doctor, my time is getting very short — at my age there's no cure for my back. Doctors keep old people's hearts pumping only to live and suffer more, instead of letting them go. Please send me something to keep me from suffering." It is my impression that this patient wants to die. Does she have the right to die?

Doctors find they can cure sometime, they can relieve often, but they can comfort always. I will do my best to comfort this patient, try to relieve her, but I cannot cure her. I cannot end her misery nor can I relieve her mental anguish. I have never subscribed to the philosophy of mercy killing. However, I know nothing more tragic than to see a person waste away slowly in pain.

The prevalent attitude among many members of the medical profession, spurred on by the apparent success of mechanical respirators, cardiac pacemakers, and artificial kidneys, is to fight for the life of every patient with all the power at their command. This is good — when there is hope of salvage of a useful life; but when life hangs by a tenuous thread and the future

almost certainly holds no reasonable chance of recovery, a real injustice is done to the individual and to the family. We need to strike a sensible balance between the extremes of too quickly throwing in the sponge on the one hand, and prolonging death rather than life on the other.

As a society, the American attitude toward death is neurotic. We live in a death-denying society. Death is no longer a part of life. In days gone by people died at home surrounded by familiar faces. Now over 80% of the American population die in a hospital or a nursing home. In the final crisis, when the dying patient needs to be at home surrounded by his family more than any other time in his life, he is sent off to an emergency room. Someone takes blood, X-rays, EKGs; rarely does that patient have any choice about these assaults.

Under the pretext of saving him, we suddenly begin to treat the dying patient as if he had no opinion or rights of his own. If we are honest with our own "gut reactions" we do many of these things in a depersonalized, mechanized, and sometimes a dehumanized manner — not to fulfill the patient's needs, but to satisfy our own needs. We use monitors, respirators, and all the other modern gadgetry because we ourselves need to believe we are curing, treating, or prolonging life. Often we are only prolonging death. To a physician, death of a patient is evidence of a failure, and consequently death is accepted reluctantly. Dr Elizabeth Kubler-Ross, a noted thanatologist, relates an incident in which she visited a 600-bed general hospital and asked to see the dying patients.¹ The staff denied that there were any dying patients in the hospital. Can you believe there were no dying patients in a 600-bed general hospital?

Let us return briefly to the philosophical attitude about death. Christianity teaches that in dying we are born to eternal life. Caught up in the here-and-now reality of day-to-day activity the accent for us is on living. We Christians say we believe in life after death, but most of us have some nagging doubt. Most of us are not ready to trade the known for the unknown. As Shakespeare so beautifully phrased it in Hamlet:

*"To grunt and sweat under a weary life,
But that dread of something after death,
The undiscovered country from whose bourne
no traveler returns,*

*Puzzles the will and makes us rather bear
those ills we have, than fly to others that we
know not of."*

We need to bring today's topic—"The Right To Die" — into its proper perspective by considering the true magnitude of the problem. Are we talking about incidents that occur once a year, once a month, once a week, or every day? Of course as far as the individual patient is concerned, the right to die need be considered but once in a lifetime. I have been an active practicing family physician for 24 years. I would estimate that I have had to wrestle with this problem not once a year, but at least a half-dozen times a year. We have no accurate surveys of the frequency of situations involving dying patients who are candidates for the type of decision making we are discussing.

Most incidents of death — probably 95% — occur after all recognized, ordinary therapeutic measures have been carried on until the end with no thought of "pulling the plug." It is the case requiring unusual care that drags on — which calls for decision making in the death process. I would estimate that this situation happens at least 1,600 times a year in Maryland. I say this because as many as 5% of dying patients require special decision making. With approximately 33,000 deaths annually from all causes in Maryland, we are talking about some 1,650 individuals. Now there are over 4,000 licensed physicians in Maryland so the average doctor is not confronted with this problem very often. It depends on the setting in which he works. A physician who works in the Shock Trauma Unit at the University of Maryland Hospital may become involved in this type of decision every week. An anesthesiologist would likely not be confronted by such a situation once a year. We conclude that the problem is frequent enough to consider seriously and it will become a more frequent problem.

In family practice, I have dealt with many patients in the home setting. By frank, honest, but gentle discussion with the family, and the patient if possible, one can usually sense the feelings of those involved on the matter of how hard to push in a terminal illness. It is understood that a decision about withdrawing life support systems should be jointly made by the physician, the patient's family, and religious advisors who may be involved. Certainly one individual should not be called upon to make an independent decision. There have been incidences of prolonged guilt and hostility in families when one member takes upon himself the responsibility of such an act.

Since this is a meeting of the legal profession, may I offer a medical person's viewpoint of the legal aspects?

New medical techniques for prolonging life force both the medical and legal profession to reevaluate their traditional attitudes toward life and death. New problems emerge from the following recurrent situation: A comatose patient shows no signs of brain activity; according to the best medical judgement his chances of recovery are exceedingly small, yet he can be sustained by a mechanical respirator. How long should this physician keep him alive? A week? A month? Six months?

According to one line of thought, the physician's leeway in caring for a hopeless patient is limited indeed. He may turn off the respirator, but only at the risk of prosecution and possible conviction of manslaughter. This approach of equating a physician's act of turning off a mechanical respirator with a gunman's killing, to me, is not realistic. Yet we are faced with the possibility of this interpretation.

I am not qualified to argue the elements of common law murder; nor whether the physician's discontinuing aid to a terminal patient is an act or an omission; nor to differentiate between the theory of causing and permitting in acts of omission. I believe we can agree, however, that allowing the patient the right to die should depend on the relationship between the parties involved. This relationship should set the limits of the physician's legal duty to his patient.

Thus we arrive at the following conclusions. The doctors' duty to prolong life depends on his relationship with his patient, and in a typical case that relationship depends on the expectations of the treatment he will receive. Those expectations, in turn, are dependent on the practices prevailing in the community at the time, and practices in the use of respirators to prolong life are no more and no less than what doctors actually do at a given time and a given place.²

The law is not a static thing; it is a problem-solving mechanism. Changing morality changes the law. The medical profession faces the challenge of developing humane and sensitive customary standards for guiding decisions to prolong lives of hopeless patients. The profession cannot shirk this challenge.

The doctors must adopt a policy that will stand a legal challenge.

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Case Report

CARCINOMA OF THE E G JUNCTION MIMICKING ACHALASIA

C TIMOTHY BESSENT BS
CEZAR A LOPEZ MD
ARTHUR E COCCO MD

From the St Joseph Hospital and the Johns Hopkins University School of Medicine, Baltimore.

Mr Bessent is a senior medical student at the University of Maryland School of Medicine, and had a summer fellowship in Gastroenterology at St Joseph Hospital.

Dr Lopez is a Fellow in Gastroenterology at St Joseph Hospital.

Dr Cocco is Instructor in Medicine at the Johns Hopkins School of Medicine and Chief of Gastroenterology at St Joseph Hospital and Church Home and Hospital, Baltimore.

Information and reprint requests to Dr Cocco, 7620 York Rd, Baltimore Md 21204.

Abstract

A case of invasive carcinoma involving the gastroesophageal junction with metastasis to the esophageal myenteric plexuses which mimicked idiopathic achalasia is described. Historic, roentgenographic, manometric, esophagoscopy, and histologic findings are included. Problems presented to the managing physician when confronted with megaesophagus are discussed and the relationship of achalasia and carcinoma is reviewed.

Introduction

Physicians confronted with megaesophagus must entertain several diagnostic possibilities which include achalasia (cardiospasm), benign stricture, or neoplasm. Since all may mimic classical achalasia, initial historical symptoms of motor dysfunction and roentgenographic features may lead the unsuspecting physician to a therapeutic dilemma, especially if the standard medical approach of transesophageal pneumatic dilation is employed.¹ This paper presents a case in which the diagnosis was confirmed only after thorough investigation. The purpose of this report is to question the possibility of malignancy preceding and thus being a cause of achalasia and to review the experiences of others recorded in the literature.

Case History

BR, a 79-year-old white male, was referred

for evaluation and treatment of dysphagia. The patient admitted to slow eating habits and an awareness that for many years "food went down slowly." During the year prior to admission, he recognized progressive dysphagia and nocturnal regurgitation. He denied pyrosis at any time and stated that he vomited undigested food periodically.

Other complicating medical problems included atherosclerotic coronary heart disease with cardiomegaly and atrial fibrillation, iron deficiency anemia, and mild azotemia. Pertinent laboratory data included a hematocrit of 30%, total protein 5.8 gm%, albumin 3 gm%, and BUN 32 mg%. Chest X-ray suggested a wide mediastinum with an air-fluid level and right-lower-lobe pneumonitis.

Barium swallow revealed a markedly dilated esophagus that supported the barium column above the aortic arch and a tapering "bird beak" esophagogastric junction. A gastric air shadow was not seen (see Fig 1).

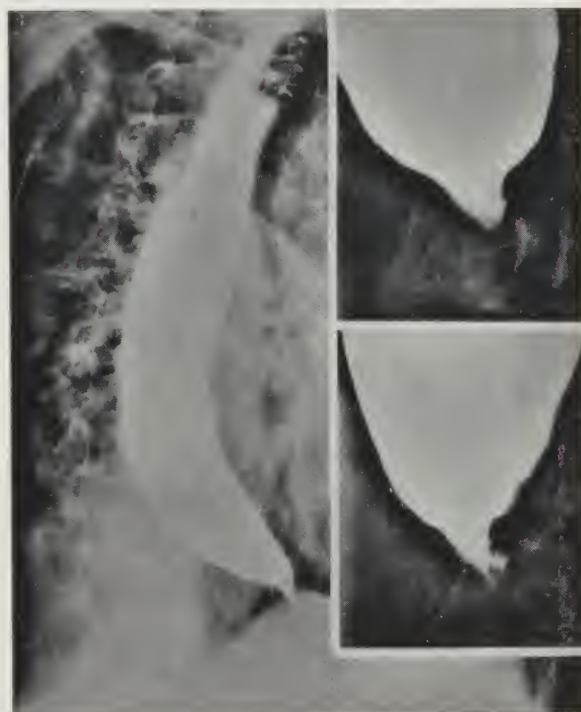


Fig 1: Barium swallow: dilated esophagus supporting a barium column with tapering distal segment.

Esophageal manometric studies with perfused open-tipped catheters demonstrated that the esophagogastric high-pressure zone was normal but failed to relax with dry or water swallows. Progressive peristalsis was not recorded in the body of the esophagus. After subcutaneous injection of 10 mg methacholine chloride (Mecholyl), there was no alteration of the baseline esophageal pressures and spasm was not recorded (see Fig 2).

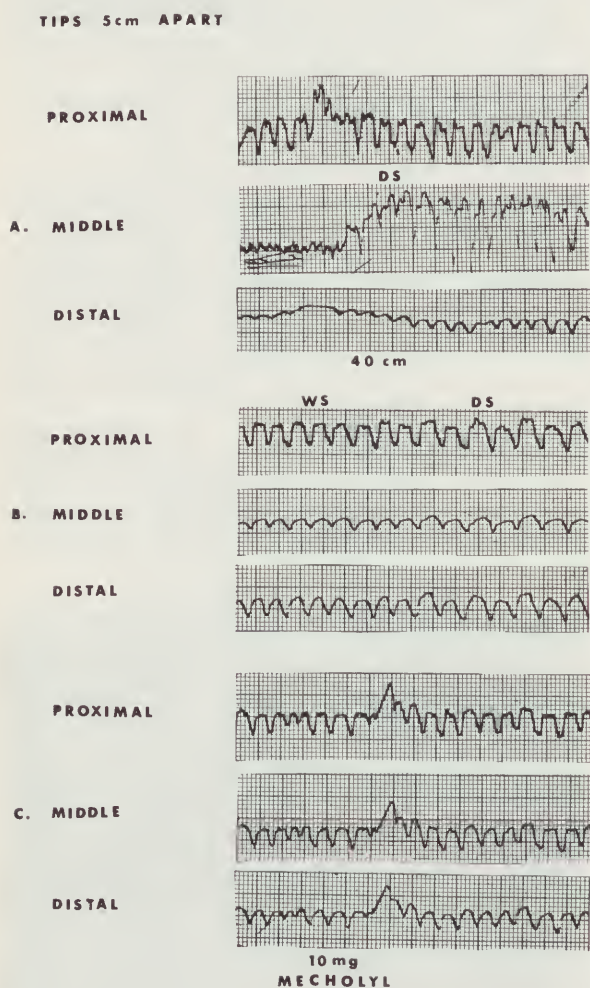


Fig 2: Esophageal motility recording:

A) catheters withdrawn toward cephalad direction: proximal tip in esophagus, middle tip at the high pressure zone, and lower tip in the stomach. Failure of high pressure zone to relax with dry swallow.

B) All tips in lower esophageal segment: no response to water or dry swallow.

C) All tips in lower esophageal segment: no change in motility after Mecholyl although tachycardia and flushing were observed.



Fig 3: Endoscopic photo of distal esophageal segment. Note disruption of mucous membrane; biopsy interpreted as adenocarcinoma.

Endoscopic examination of the esophagus revealed a greatly dilated esophagus with a narrow, tapering distal segment. The mucosa in the area of the esophagogastric junction was disrupted by a dirty gray irregular appearance (see Fig 3). The luminal diameter was severely compromised and manipulation of the scope into the stomach was not possible. Biopsy and cytologic specimens were obtained. Histologically, both were interpreted as adenocarcinoma.

The patient continued a downhill course with features of progressive weight loss, congestive heart failure, and recurrent respiratory infections. He expired two months after the diagnosis was established. Postmortem examination was obtained and sections from the esophagogastric junction revealed features of adenocarcinoma. In addition, numerous esophageal myoneural plexuses were found to be infiltrated with neoplasm (see Fig 4).

Discussion

The presumed mechanism producing the clinical syndrome of achalasia is a quantitative or qualitative defect in the ganglionic cells of Meissner's and Auerbach's plexuses.²⁻⁸ This syndrome is usually idiopathic but numerous cases document that *Trypanosoma cruzi* may produce an indistinguishable clinical picture in the esophagus.⁹⁻¹² The association of achalasia and carcinoma of the esophagus or cardia are well recognized and reviewed in the medical and surgical literature.¹³⁻¹⁸ Investigators have reported that the association of achalasia and carcinoma

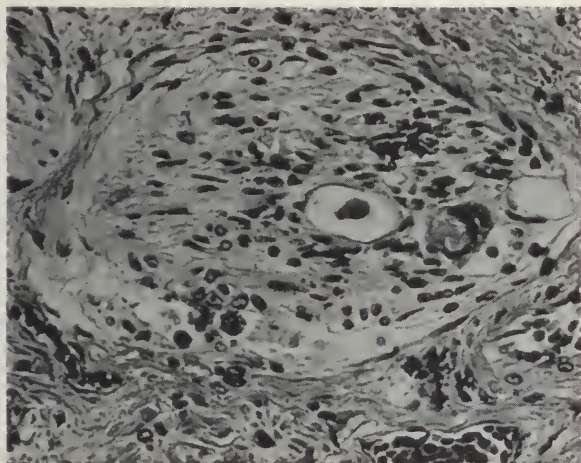


Fig 4: Low (x200) and high (x500) power views of Auerbach's plexus invaded by poorly differentiated adenocarcinoma.

ranges from zero to 29%.^{13,19-27} Where symptoms of achalasia clearly antecede the recognition of neoplasm, the time interval reported ranges from 17 to 30 years.¹³⁻¹⁴

In the approach to individual case assessment, various historical features and diagnostic tests may aid in the differentiation of achalasia and carcinoma. The usual patient presenting with achalasia is less than 40 years old and the duration of symptoms is frequently greater than one year, while the average age of the patient presenting with carcinoma of the esophagus is 62 years.^{22,25,28-29} Exceptions in either case are common and age offers little help in the differentiation.

Gastrointestinal bleeding is rare in achalasia but frequent with carcinoma.³⁰ Roentgenographic studies should be evaluated with special emphasis on the position and appearance of the narrowed segment of the esophagus. Tumors may manifest by absence of the gastric air bubble although this is more commonly noted in achalasia. The soft tissue thickness between the fundus of the diaphragm and/or barium flow into the stomach, especially when studied by cinerentgenography, is helpful; nevertheless, in some instances the findings are indistinguishable.³¹⁻³³

Others have experienced perplexing situations similar to the case presented. Gastric carcinoma is reported as a cause of esophageal achalasia.^{31,34-38} There are several reports of manometric studies and positive Mecholyl tests in patients with gastric adenocarcinoma, metastatic involvement of the esophageal ganglia, and secondary esophageal achalasia as was found in the present case.³⁹⁻⁴⁰

Manometric studies provide the clinician with

the best opportunity to correctly diagnose achalasia. The motility findings in this case are classical, with the exception of Mecholyl test. In our patient, a 10-mg subcutaneous injection of methacholine chloride (Mecholyl) failed to increase baseline esophageal pressures. In view of the patient's precarious cardiac status, progressive dosage was not utilized. Whether a larger dose would have yielded a positive response is conjectural since others have noted variability in the esophageal response to this agent.⁴¹⁻⁴³ Ellis and Olsen believed that a more reliable basis for diagnosis of achalasia is provided by the characteristic motor abnormalities of elevated resting esophageal pressures, aperistalsis in the esophagus, and failure of adequate relaxation of the esophagogastric sphincter with deglutition.⁴⁴ Herrera et al concluded that esophageal hypersensitivity to Mecholyl should be interpreted as representing anatomic and/or physiologic derangement of the myenteric plexus.⁴⁰

Endoscopy is an invaluable tool in the differential diagnosis. During this procedure, difficulty in manipulating the scope into the stomach should raise the suspicion of a diagnosis other than achalasia. Multiple biopsies and cytological washings following direct brushing should be obtained. At this point, the reader is reminded that if biopsies are obtained during endoscopic diagnostic evaluation, adequate time should elapse prior to a pneumatic dilatation attempt, since the continuity of the mucous membrane is felt essential in preventing perforations.

We personally have recognized biopsy sites endoscopically as long as two weeks after esophageal biopsy. In the same context, we have come to appreciate cytologic studies of the esophagus as very efficient in the detection of cancer and have instances of positive cytologic specimens when multiple biopsies were negative for neoplasms (data in publication).

Most of the literature concerning achalasia and neoplasm reflects Rake's belief that stagnation produces acute esophagitis which progresses to chronic esophagitis and eventually degenerates into malignancy.^{4,45} In Just-Viera and Haight's collected review of 109 patients, the location of the complicating carcinoma was noted. In this study, tumors arose in the upper third of the esophagus in four patients, in the middle third in 56, in the lower third in 42, and in multiple sites in seven.¹³

In our endoscopic observations of patients with idiopathic achalasia, the distal esophagus usually demonstrates, on gross and histologic examination, a normal mucous membrane. In addition,

since esophagitis is usually an acknowledged sign of gastroesophageal reflux, this feature always stimulates us to look beyond achalasia as the cause of the esophageal obstruction. Thus we view the prevailing concept of Rake as speculative and in need of additional documentation.

Squamous cell carcinoma is incriminated as the most common malignant tumor complicating achalasia.¹³ The postmortem examination of our patient revealed undifferentiated adenocarcinoma in the region of the E G junction. As demonstrated in Fig 4, there was metastatic invasion of the perineural areas in the distal esophagus. The intriguing thesis has been postulated that such metastasis could be the pathogenesis of secondary achalasia.³⁹⁻⁴⁰

Our case tends to support and reinforce the possibility that carcinoma can precede the achalasia. However, in this case as well as in others,

when all the clinical data have been collected and analyzed the question still remains: did the achalasia precede the carcinoma, carcinoma the achalasia, or did the two occur simultaneously but independently?

References

A complete list of the 45 references used with this article may be secured from Dr Cocco.

The first medical school specifically for Indian students, a school which will teach traditional Navajo medicine along with modern medicine, plans to open this month. It will be operated by the University of New Mexico and funded by a \$4.7 million grant. Until buildings are constructed, the school will use facilities of the Navajo community college and public health service on the 25,000-square-mile reservation at Window Rock Ariz.

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Case Report

CEREBROSPINAL FLUID RHINORRHEA, AQUEDUCTAL STENOSIS, AND THE EMPTY SELLA

JACK KUSHNER MD
ISADORE MESCHAN MD
EBEN ALEXANDER JR MD

From the Dept of Neurosurgery, Anne Arundel General Hospital, Annapolis Md; and the Dept of Surgery, Section on Neurosurgery, and Dept of Radiology, Bowman Gray School of Medicine, Wake Forest University, Winston-Salem NC.

Information and reprint requests to Dr Kushner, 20 Ridgely Ave, Annapolis Md 21401.

Abstract

This paper describes the case of a 29-year-old woman with cerebrospinal fluid (CSF) rhinorrhea resulting from increased intracranial pressure caused by cerebral aqueductal stenosis. In addition, she was found to have an "empty sella syndrome" at operation, thought to be the result of the markedly dilated hypothalamic extension of the third ventricle. The authors underline the importance of directing attention to the CSF fistula.

Key words: CSF rhinorrhea, aqueductal stenosis, empty sella

Introduction

In the past, cases have been reported of spontaneous cerebrospinal fluid (CSF) rhinorrhea associated with craniostenosis,¹ Arnold-Chiari malformation,² posterior fossa tumors,³ and aqueductal stenosis.^{1,4} Eleven patients have been reported who had CSF leakage with an "empty sella syndrome."^{5,6} Four patients have also been listed who had spontaneous "high pressure CSF rhinorrhea," attributed to a lesion obstructing the flow of CSF;⁴ these patients did not have an empty sella syndrome. This report documents a case in which the patient had CSF rhinorrhea associated with both aqueductal stenosis and the empty sella syndrome. It also relates an effective surgical approach to this problem.

Case Report

A 29-year-old woman entered the hospital complaining of headaches. Although these headaches began at age 14, she believed that they had increased in severity and frequency since her marriage eight years before. Frequently the headaches became so intense that she went to bed at 5:00 PM and slept through the night.

The headaches did not involve any particular area. There was no associated nausea or vomiting. For the past two years, clear fluid had leaked from her nose. At times she had observed enough leakage on her pillow to produce a stain measuring six inches in diameter. Seven weeks before her admission to this hospital, she had been unconscious in her local hospital for a period of two days with a severe case of pneumococcal meningitis. This infection was treated extensively with antibiotics, and she responded well without sequela. She complained of no visual difficulties.

Physical examination revealed a small and alert young woman. Blood pressure measured 100/70 and her pulse rate was 70/min. No bruits could be heard either over the head or the neck. She was able to smell through both nostrils. The pupils were equal and reacted well to light and accommodation. Funduscopic examination showed pale discs to be present. There was no papilledema. No spontaneous venous pulsations were seen. The visual fields were full. Extraocular movements were normal and there was no nystagmus. The remainder of the physical examination was normal. By changing her position from the supine to the sitting posture and by compressing her jugular veins, 1 cc of CSF could be expressed from the left nostril. The glucose in this clear fluid measured 70 mg/100 cc; a simultaneous serum glucose measured 120 mg/100 cc.

On admission the complete blood count, urinalysis, and SMA-12 were negative. The serologic test for syphilis was normal. The specific gravity of the urine was 1.023.

Plain skull films showed an enlarged sella turcica (Fig 1). Bilateral carotid arteriography (Fig 2A, 2B) demonstrated marked hydrocephalus. Although a small posterior fossa was not noticed on the plain skull X-rays, it was seen on the films obtained during the cerebral arteriography and venography. A brain scan was negative. RISA-cisternography showed the isotope to remain in the basal cisterns for a period of 20 hrs, but never entered the ventricular system.



Fig 1: Lateral view of sella turcica. The anteroposterior dimension is increased and there is evidence of some erosion of the dorsum sellae and minimal erosion of the posterior clinoids. The sphenoid bone and air space appears densely sclerotic suggesting chronic inflammatory change.

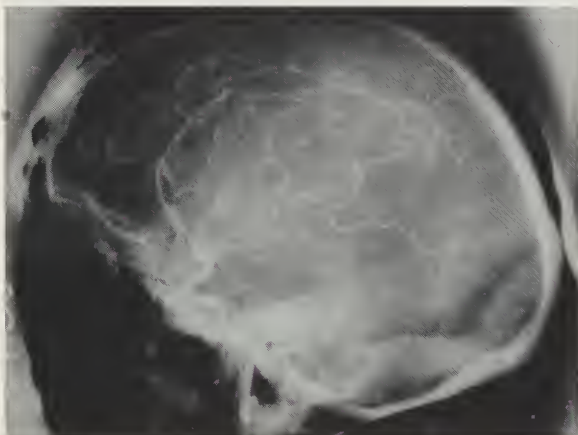


Fig 2A: Representative lateral view of right carotid arteriogram. The carotid siphon appears "open," and there is a "sweep" of the anterior cerebral arterial complex. The low-lying lateral venous sinus impression is noted here as well as the low-lying lamboid suture.

Ventriculography (Fig 3A, 3B, 3C) was done with a normal opening pressure. The lateral ventricles and the third ventricle were grossly enlarged (Fig 3A). The Sylvian aqueduct did not fill. The cortex measured 3 cm in thickness. The anterior third ventricle went well into the sella turcica. An additional 8 cc of air was introduced into the lumbar subarachnoid space. This pneumoencephalogram demonstrated a small but normal fourth ventricle (Fig 3B, 3C), and the Sylvian aqueduct was visualized but was found to be occluded. From these studies it was concluded that this patient had CSF rhinorrhea resulting from aqueductal stenosis. Furthermore, an empty sella syndrome was suspected.

An approach was made through a craniotomy in the frontal region. The enlarged sella turcica was almost empty except for the presence of pituitary gland at the base posteriorly. In the anterior region of the sella there was a small aperture which was believed to be the site of the leakage. Muscle and fascia were taken from the right temporal region and were packed into this area. A small piece of stainless steel mesh

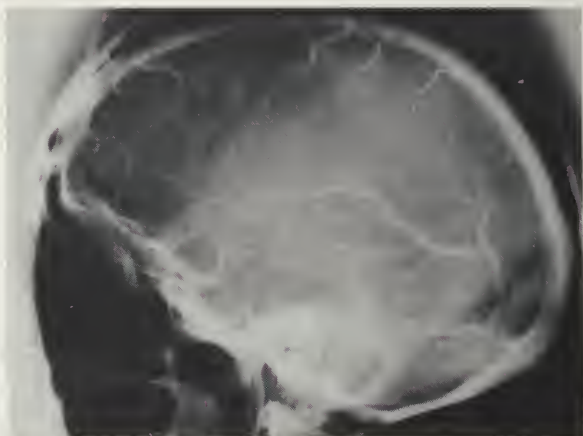


Fig 2B: Venogram phase demonstrating the low position of the lateral sinus and sinus confluens indicative of the small posterior fossa coexisting with the cerebral aqueductal stenosis.



Fig 3A: Lateral ventriculogram with head in inverted position demonstrating the greatly dilated third ventricle, particularly in its hypothalamic extension. The entire hypothalamic portion of the third ventricle appears "diverticulum-like" and appears to fill the enlarged sella turcica with the exception of a small segment posteriorly. There is a dimple along the floor of the third ventricle at the site of the cerebral aqueductal stenosis with no air extending into the cerebral aqueduct or into the posterior fossa. The massa intermedia happens to be small in this case. The lateral ventricles are markedly dilated.

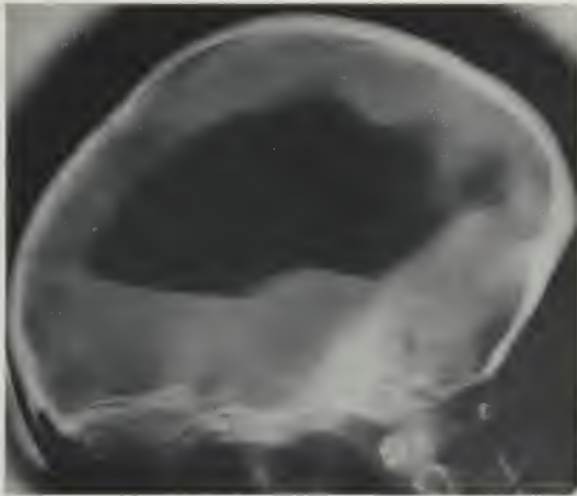


Fig 3B: Lateral view following introduction of a small amount of air into the lumbar subarachnoid space with demonstration of a small fourth ventricle and no filling of the cerebral aqueduct.



Fig 4: Lateral view of the skull following insertion of the muscle with the silver clip and the stainless steel mesh which are depicted by the arrows.

was placed over the muscle, and a piece of Gelfoam was inserted over this (Fig 4). An opening measuring 1.5 cm was then made in the thin lamina terminalis which permitted CSF to escape into the subarachnoid space. A Rickham reservoir was placed in the left lateral ventricle through a Burr hole in the left frontal region for future measurements of pressure. The brain was reexpanded with 200 cc of Tis-U-Sol which was injected through the Rickham reservoir. The Tis-U-Sol escaped through the artificial opening in the lamina terminalis.

Postoperatively the patient did well except that she did have a mild, transitory diabetes insipidus. In addition, there were some minor alterations in her personality.



Fig 3C: PA view of the fourth ventricle coincident with the film obtained in Fig 3B. The fourth ventricle appears small, and the cisterna ambiens are delineated on either side of the brain stem, but no air is seen in the region of the cerebral aqueduct. The cisterna cerebello-medullaris are well demonstrated on either side of the fourth ventricle.

When she was readmitted for reevaluation of persistent headaches on Feb 20, 1970, two months after the initial craniotomy, the physical examination was normal except for pale discs seen on funduscopy examination.

A ventriculogram showed that she still had marked hydrocephalus. No air was seen over the cerebral cortex surface which suggested that the third ventriculostomy had not functioned as expected. On Feb 23, 1970, a ventriculo-atrial shunt was inserted. Three months after the second operation, the urinary incontinence was controlled and the peculiar personality characteristics had reverted to normal.

Discussion

Etiology. The first well documented case of spontaneous CSF rhinorrhea was that of a hydrocephalic child named Thomas Anderson.⁷ Miller (1825) related that while this child sat by the fire with his head propped by a board there was an "occasional dropping of water from his nose, generally to the extent of one or two dramglassfuls daily." At the postmortem examination an opening was discovered near the crista galli through which the CSF leaked through the nose. Having witnessed several other cases similar to the foregoing, Thomson⁸ recognized and described more completely the clinical significance of this process.

Locke⁹ listed three possible routes for the egress of CSF which was under pressure. He discussed the possibility of a rupture of the arachnoid which would pass through the cribriform plate with the olfactory nerve filaments. With others, he suggested that there might be a persistent

embryonic olfactory tract ventricular lumen.⁹⁻¹¹

Busch¹² demonstrated that the sellar diaphragm might be absent. He examined this area in 788 autopsies and found no sellar diaphragm in 5.5% of the cases. None of these cases had known pituitary disease. The subarachnoid space not only lies within the sella turcica 20% of the time,¹³ but it has been demonstrated between the sellar diaphragm and the rostral part of the pituitary gland¹⁹ and around the pituitary gland.^{15,16} When there is a deficient sellar diaphragm and dural lining in the sella, CSF may easily seep from the subarachnoid space, through the sella, and into the sphenoid sinus.

In recent years there has been considerable discussion about the various mechanisms of the pathogenesis of CSF rhinorrhea.^{1,4,6,15,17-23} Similarly, several attempts have been made to explain the empty sella syndrome.^{6,24-26} The etiology of both of these processes appears to be directly related to CSF hypertension²⁷ and perhaps to a deficient sellar diaphragm.^{21,24}

Clinical Course. The aqueductal stenosis in this patient cannot be attributed to mumps,²⁸⁻³⁰ nor was there evidence of any respiratory disease such as influenza. She does demonstrate some of the characteristic features of nontraumatic rhinorrhea. Women are twice as prone as men to develop CSF rhinorrhea.¹ This patient at 29 years of age is younger than the average of 43.¹ Her sense of smell was intact prior to surgery. She was troubled with headaches which were less intense in the morning, possibly after some CSF had leaked while during sleep. She had neither an arachnoid cyst nor any evidence of intracranial air. Her nasal flow was intermittent and insidious. The ventriculogram clearly showed the presence of marked obstructive hydrocephalus. This ventricular enlargement was due to the aqueductal stenosis and this obstruction produced the pressure which caused the thinning of the lamina terminalis and the enlarged sella turcica. The pressure was also responsible for the leakage of the CSF into the sphenoid sinus.

It is noteworthy that this patient's case differs from that recently reported by Rovit⁴ in that she had an empty sella syndrome as well as aqueductal stenosis and CSF rhinorrhea. The intracranial pressure would probably have been higher had she not been leaking CSF. She did have pale discs, which probably were the result of chronic increased intracranial pressure. Presumably, the CSF in the ventricles leaked through the dilated hypothalamic extension of the third ventricle into the sellar area³¹ through the thin lamina terminalis intermittently. This process displaced

and compressed the pituitary gland producing the empty sella appearance. A small aperture was present in the anterior region of the sella which was thought to be the site of the leakage.

Surgical Therapy

The surgical therapy of CSF rhinorrhea should have a twofold purpose: 1) to close the leakage site, and 2) to relieve any obstruction to the flow of CSF. It was with these intentions that the initial operation was performed. First, the empty sella was exposed and the leakage was stopped with muscle, fascia, and stainless steel mesh. Secondly, a third ventriculostomy was done in the hope that this would relieve the aqueductal stenosis and facilitate the flow and absorption of CSF. This procedure was not successful as evidenced by the hydrocephalus on the second ventriculogram. Subsequently, a ventriculo-atrial shunt was inserted which relieved the obstruction of the CSF.

We disagree with those who advocate the use of a shunt initially in the treatment of CSF rhinorrhea. Cases of therapeutic failure with this method have been well documented.^{4,21} We wish to stress the importance of obliterating the actual leakage site.

When selecting the proper material for the primary closure of the fistula, we believe that stainless steel mesh is the material of choice. This surgical approach and method have been employed in our hospital for 20 years in over 100 cases, and there has been only one recurrence of the CSF leakage regardless of etiology, be it traumatic or nontraumatic. Other materials^{32,33} such as Isobutyl-2 cyanoacrylate and Biobond³⁴ may serve equally well, but experience with these compounds is limited, and the monomer is mildly neurotoxic.^{35,36}

References

A complete listing of the 36 references used with this article may be secured from Dr Jack Kushner, 20 Ridgely Ave, Annapolis Md 21401.

Auxiliary Contribution

At the annual meeting of the Woman's Auxiliary of St Agnes Hospital (Baltimore), Mrs Louise Kaye, President, presented a check for \$32,000 to Sister Alberta, Hospital Administrator. This is the largest amount donated by the Auxiliary in a single year.

\$27,000 of the funds will be used to equip a new stat (emergency) laboratory, while the remaining \$5,000 has been designated toward purchase of an operating room table.

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

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PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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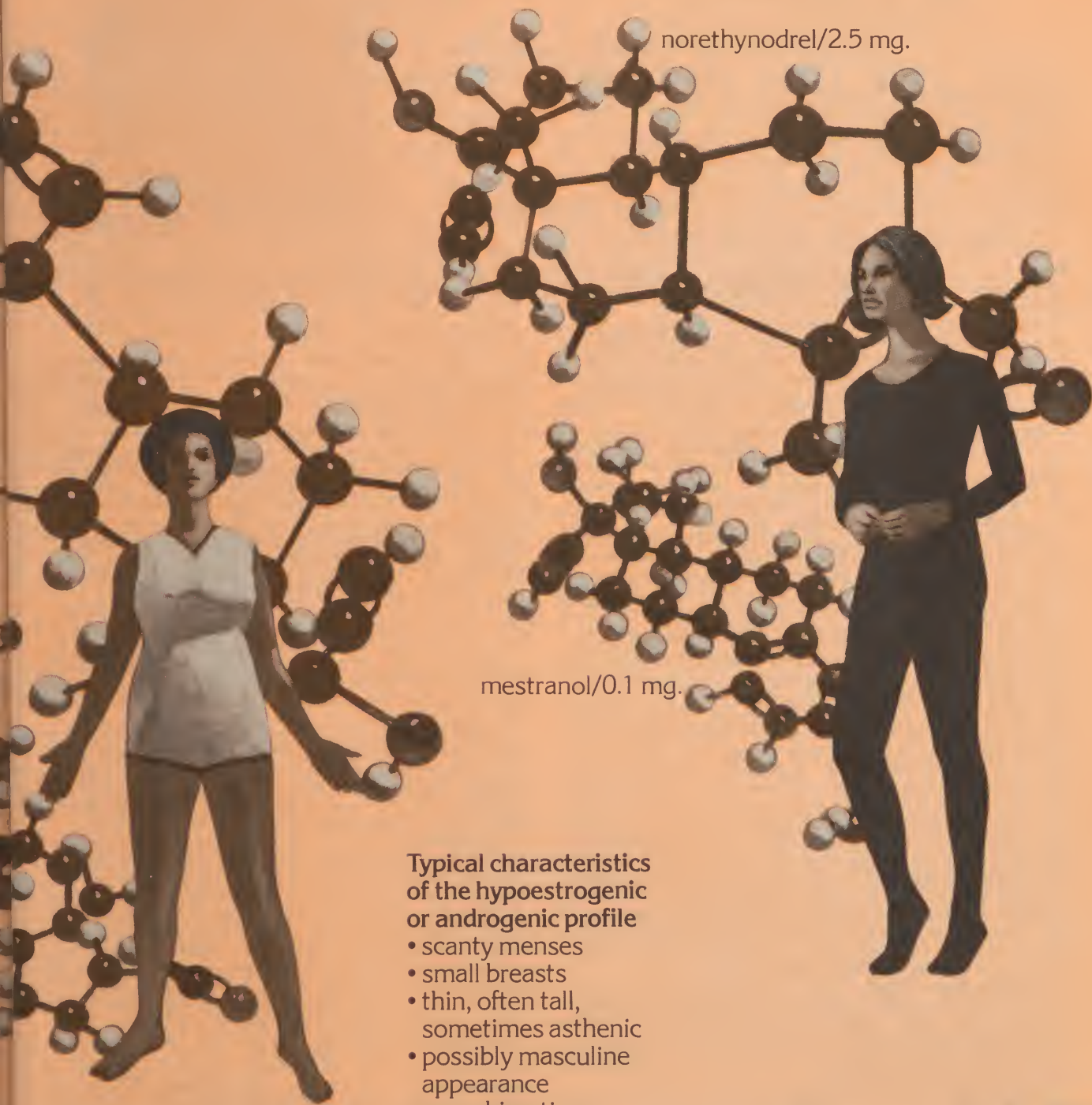
- heavy flow
- large breasts, sometimes fibrotic; nipples well pigmented
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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain¹⁻³ leading to this conclusion, and one⁴ in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible

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influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

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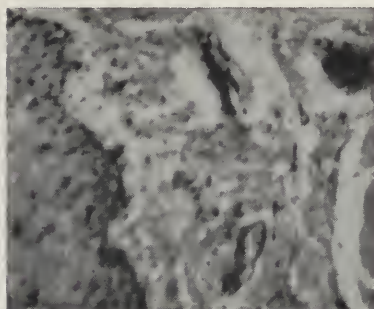
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pathology

IN SEARCH OF RELIABILITY IN THE CLINICAL LABORATORY

The physician evaluates the patient by history and physical examination. As an extension of the physical examination, he orders various clinical laboratory tests. These analyses are used to screen for unsuspected diseases, confirm the presence of suspected diseases, aid in prognosis, and to follow therapeutic response. What determines the degree of reliance the clinician can put on these analyses? And, what problems does the laboratory face in producing reliable measurements? And, finally, how can these problems be solved or at least minimized?

In getting at general answers to the above questions, first consider the problem of accuracy of a test. Accuracy in this context is defined as results as close to the actual value as possible. Because any measuring method has an inherent "error," no method will give the "exact" values. Clinical laboratories use both specific and non-specific testing methods. While some clinical laboratory methods are nonspecific to the point of horrifying a "purist" chemist working in an industrial or standards laboratory, these methods give clinically useful results.

For the following reasons the clinical laboratory uses these less accurate methods: 1) generally a limited specimen volume, 2) generally limited time to obtain results, and 3) analysis of complex solutions and not a simple dilute solution with a single substance of interest. In reference to the last point, some substances in the body fluid interfere with a determination while others augment results.

As the specificity and accuracy of testing methods improve, a hierarchy of tests for a particular substance develops with the most accurate used as the referee method against which the results of the next most accurate method (the reference method) are compared. The latter method is then used to compare results of the "bench" method used routinely in the laboratory. As improved methods are developed that are reasonably

rapid and easily run with equipment that is not too costly and complicated, reference methods become bench methods—thus increasing the accuracy of the routine results.

Let us assume there are applicable methods that are "accurate." Do we have other considerations concerning the reliability of a test answer? Yes. The major problem in the clinical laboratory is precision; that is how reproducible are the results of the test. The following causes lead to inherent varying degrees of nonreproducibility:

1) Instrument—"Drift" of instrument once calibrated due to fluctuation of electric power supplied, specimen (especially protein) or reagent build-up in the instrument, "fatigue" of lamp if present and other electronic components.

2) Glassware—Variation in calibration and cleanliness.

3) Reagents—These may deteriorate after standardization of the method.

4) Varying skills of personnel performing tests. These are particularly true in chemical procedures but apply to a varying degree to all clinical laboratory determinations.

To check on the degree of precision of a method, the laboratory uses a statistical system of quality control. This is not a measure of the accuracy of a test—only its precision. Quality controls with known values are used with each "run." These are as much like the unknown as possible and are handled in the same manner as the unknown specimen. Statistical limits are set for each procedure—usually designated as standard deviations from the mean. If the results of the quality control specimen are "in control," that is within specified limits, it is assumed the unknown specimens are "in control" and are reported by the laboratory.

Now that the laboratory has generated an accurate and precise results, what considerations

Have you ever seen a realistic chart on food cholesterol?

Do you consider shrimp to be low in cholesterol and butter to be high? Actually, there's 12-1/2 times as much cholesterol in a 3-1/2-ounce (100 grams) serving of shrimp as there is in a teaspoon pat (5 grams) of butter! The chart below on cholesterol content of various foods takes normal servings into account.

MEAT, FISH AND EGGS

	Cholesterol (mg)
Liver (3-1/2-oz. serving-cooked)	438
Eggs (1 large)	252
Oysters (6 to 9 Pacific Small-Meat only)	120
Lobster (3-1/2-oz. serving) ..	85
Shrimp (10 small)	150
Clams (10-meat only)	60
Veal (3-1/2-oz. serving) ..	99
Pork (3-1/2-oz. serving) ..	88
Beef (3-1/2 oz. serving) ..	91
Lamb (3-1/2 oz. serving) ..	100
Fish (3-1/2-oz. serving) ..	50-60
Chicken (3-1/2-oz. serving) ..	87

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Whole milk (8-oz. glass) ..	34
American cheese (1 oz.) ..	28
Ice Cream (1/4 pint)	27-43
Heavy Whipping Cream (1 tbsp.)	20
Creamed cottage cheese (1/2 cup)	11-24
Butter (1 pat)	12
Gouda cheese (1 oz.)	21
Yogurt (1/2 cup)	8
Half and half (1 tbsp.)	6
Skim milk (8-oz. glass) ...	5

Cholesterol Values from:

Journal of the American Dietetic Association: Feeley, R. M. *et. al.*; "Cholesterol Content of Foods"; 61:134, August 1972.

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must be used in evaluating the appropriateness of the test results? First, what framework does he have to compare the results against? Is it "normal," high, or low? How are these defined? Man is subject to the variations of any biological system. This makes a definition of the normal values for a particular test difficult, particularly since the test method also has its variation. Age, sex, race, geographic location, activity, and diet have varying effects on laboratory results.

To overcome these variations, we study a "healthy" population under fairly controlled conditions to determine the central tendency (mean) of the group for the test at question using the well-known bell-shaped curve to study the frequency of various results. Since "most" have this central value, we assume it is "normal." But, what if the results on an individual patient are only slightly high or low of the mean? Are these results pathologically abnormal or a "normal" population variation? To get around this, we establish a range of statistically determined values about the mean that are considered normal and therefore an indication of health. Values outside this range are abnormal and found only in sick patients the vast majority of the times. Much thought is still being given to the problem of normal values. A single, generally agreed upon definition is not available.

Now the laboratory has given the physician a "good" result with a reference to evaluate it against. The last consideration probably represents the biggest difficulty in using laboratory results today. As stated, the normal range for a procedure is determined on specimens from a controlled population. It is the variation in patient preparation, specimen collection and handling that gives rise to apparent "wrong" laboratory results. The patient, insofar as possible, must be under "control" conditions for the procedure. This may mean fasting or a specified time after a meal, or following a period on a specified diet; off drugs (times stated) or following administration of a drug (again times stated).

Preparation of the patient prior to testing is most important and frequently overlooked by physicians and ancillary personnel. A special word about drug effect on test results: The drug may modify body physiology and thus alter expected test results or the presence of an unsuspected drug in the specimen may alter results. The specimen and the request slip must be properly identified. More "poor" laboratory measurements result from improper identification than most other causes. It is important that the specimen be collected as prescribed for the method and, once obtained, properly handled.

Is it to be refrigerated or frozen immediately and rapidly transferred to the laboratory? Are the cells to be removed as soon as possible? Are special anticoagulants, inhibitors, etc to be added at the time of collection? All these considerations are most important in determining the end results. Without a "good" specimen the best laboratory will turn out clinically useless data.

Knowing this, how can the clinician laboratory user be sure the laboratory follows accepted current methods, and evaluates the results with a quality control program. Several approaches have been taken. The most important and effective is continuing education of the laboratory staff. The American Society of Clinical Pathologists (ASCP) and the College of American Pathologists (CAP) have sponsored programs that informed the pathologists and their laboratory staffs on newer methods and their controls and encouraged them to put them into use.

Many quality control programs are available commercially and the CAP offers one. Recently, the Maryland Society of Pathologists has started a local quality control program as part of its peer review program.

One difficulty with quality control programs using known values is personal bias. If you know what reading to expect, one tends, after multiple determinations, to get results close to the expected. To overcome this, internal and external unknowns are used. The director from time to time can insert an unknown in place of the quality control to see what results are obtained. External sponsors of unknowns include the CAP and the ASCP. The Bureau of Laboratories of the State of Maryland also has a mandatory proficiency program of unknown specimens for all licensed laboratories.

Finally, to encourage continual updating of laboratory methods, the CAP in the early 1960s started a voluntary inspection and accreditation program. In 1967, the Maryland legislature enacted a laboratory licensure law. All clinical laboratories in hospitals and private laboratories accepting outpatients in the state had to be inspected and, if found acceptable, licensed. Laboratories involved in receiving specimens interstate must also be inspected by the Federal Government through the Communicable Disease Center (CDC).

All of these efforts, which are costly, are expended to assure the clinician the most reliable laboratory results possible. If you have any questions concerning quality control or other aspects of the laboratory's efforts to maintain laboratory standards, ask the pathologist of the laboratory you refer patients to for testing.

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GONORRHEA SCREENING IN MARYLAND

LELAND C KING
JOHN D STAFFORD MD

Mr King is Public Health Advisor, Maryland VD Control Program, Division of Communicable Diseases, Preventive Medicine Administration, Department of Health and Mental Hygiene. Dr Stafford is Chief, Division of Communicable Diseases, etc.

Refer to the VD Treatment Schedule printed on pgs 54-55 of the November 1972 Journal.

The incidence of gonorrhea in Maryland in recent years has increased at an alarming rate. During 1972 more than 16,100 cases were reported from all sources within the State. This is the greatest number of infections reported in a single year since cases have been tabulated. Among the communicable diseases, gonorrhea is now the most frequently reported and, from a control standpoint, certainly one of the most frustrating with which to contend.

Approximately 80% of gonorrhea infections are reported in persons less than age 30; 35% of cases are reported among teenagers or young children, and it is in this latter group that the rates are showing the greatest increase. As expected, the majority of cases are reported from the Baltimore-Washington metropolitan area.

There is little solace in the fact that many states are also experiencing tremendous increases or that the disease is completely out of control elsewhere in the nation. It has long been obvious that innovative effective control measures are needed.

Unfortunately, venereal disease casefinding is an expensive process and established syphilis epidemiologic methods such as patient interviewing and contact tracing are largely precluded by the enormity of gonorrhea prevalence, particularly when the incompleteness of case report-

ing is considered. Probably less than 25% of all cases diagnosed are reported.

The problem is further complicated by the large number of females who are infected but completely unaware of their infection. Some authorities estimate that from 50% to 80% of women infected with gonorrhea are asymptomatic. Moreover, the Center for Disease Control in Atlanta reports that at any given time between 600,000 and 700,000 females are in need of treatment. Obviously this vast reservoir of gonorrhea in females must be reduced if the disease is ever to be controlled.

Late in fiscal year 1972, federal grant funds were made available to all states to enable them to cope with the mounting problem. Although considerable latitude was allowed each applicant state in the development of their specific plans, there are general guidelines or program elements which must be incorporated. First among these is culture screening of females between the ages of 15 and 44 who receive pelvic examinations in various public clinics, ie, venereal disease, family planning, prenatal, and OB-GYN. Secondly, male cases diagnosed in public clinics are to be interviewed for contacts insofar as possible. Thirdly, educational programs directed toward the high-risk population are to be developed.

Since culture screening of females has been routine in most of Maryland's public clinics for several years, it was decided to use grant funds to extend this service to private physicians, hospitals, and other facilities. During the present fiscal year, more than 150,000 women in Maryland will be culture tested as a result of this program.

Laboratory services have been expanded in

order to more effectively handle a large influx of culture specimens and a laboratory pickup system has been established in some areas. In addition, casefinding personnel have been hired to perform case follow-up and treatment verification of positives.

Initially, selected private physicians were contacted by letter or personally visited to solicit their participation in the program. They were encouraged to obtain a routine culture specimen from all women patients in the target age group who receive a pelvic examination. Various types of culture media, principally transgrow, are supplied without cost to the physician or patient. In many cases, specimens are picked up at the physician's offices daily and delivered to the laboratory. In areas where laboratory service is not readily available, incubators are strategically placed where physicians can drop off their specimens for later pickup. Acceptance of the program by the private medical sector has been extremely good. Early results indicate that this service was urgently needed and that it is effective. From July through December 1972, the first six months of operation, 62,592 specimens were obtained from all sources. Of these, 3,248, or 5.1% were found to be positive. The positive yield from specimens submitted by private physicians alone was a startling 3.0%.

Of course, the object is not merely to conduct an indiscriminate screening program but rather to identify problem areas where activities can be intensified and where available money and other resources can be best utilized. It does appear, however, that culture screening, although not the hoped for panacea, will have significant impact on the incidence of gonorrhea.

Physicians interested in routinely screening their female patients for gonorrhea should contact the Division of Communicable Diseases, Venereal Disease Control Section, in Baltimore. The number to call is 383-2648 or 2649.

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Transgrow, a selective medium for the transport and cultivation of *N gonorrhoeae*, is used for sending specimens to a central laboratory; on the other hand, TM plates are used when there is immediate access to a laboratory. Transgrow medium under 10% CO₂ atmosphere in bottles promotes growth of pathogenic *Neisseria* and suppresses contaminating organisms similarly to Thayer-Martin medium in plates. Transgrow medium maintains viability of pathogenic *Neisseria* for more than 48 hours at room temperature. Validity of culture results depends on proper techniques for obtaining, inoculating, and handling specimens.

The Transgrow system is a compact method for transporting and growing pathogenic *Neisseria* for identification; this system eliminates the necessity for transferring specimens to culture plates upon arrival at the laboratory.

Preliminary studies conducted by the Venereal Disease Research Laboratory and other laboratories show that a high percentage of cultures that were positive on Thayer-Martin plates, incubated soon after inoculation, were also positive on Transgrow after 48 to 96 hours in transport to the laboratory. It appears that an even higher recovery rate can be attained if the inoculated bottles can be incubated at 36 C overnight before being mailed.

In clinical application when there is access to a laboratory, Transgrow is not intended to replace existing cultural procedure using Thayer-Martin plates. Thayer-Martin medium is less expensive, cultures are easier to inoculate and read, and in most studies it has been slightly more sensitive than Transgrow. The use of Transgrow should be reserved for those situations in which, because of distance from a laboratory or other reasons, a Thayer-Martin plate cannot be used. Ideally, Transgrow can extend central laboratory services for the bacteriologic diagnosis of gonorrhea to physicians and public health workers who heretofore have had to rely on unproductive Gram-stained smears.

Inoculation

A.) Inoculate specimens on the surface of Transgrow medium as follows:

Caution: Keep neck of bottle in elevated position to minimize CO₂ loss.

- 1.) Remove cap of bottle only when ready to inoculate medium.
- 2.) Soak up all excess moisture in bottle with specimen swab and then roll swab from side to side across medium, starting at the bottom of the bottle.

B.) When possible, incubate the Transgrow bottle in an upright position at 35 to 37 C for 16 to 18 hours before mailing and note this on accompanying request form. Resultant growth survives prolonged transport and is ready for identification upon arrival at the laboratory.

C.) Package the capped Transgrow bottle and request form in a suitable container to prevent breakage and immediately transport to a central bacteriologic laboratory by postal service or other convenient means.

D.) At the laboratory, preincubated Transgrow bottles will be examined immediately for *N gonorrhoeae*; other bottles will be incubated at 35 to 37 C for 24 to 48 hours and examined.

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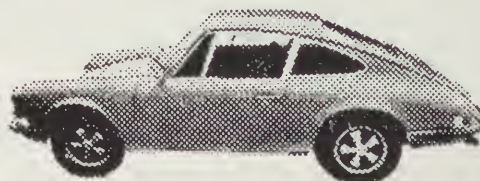
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Here and There in Medical Libraries

Every now and then we pick up choice bits of information related to the operation of medical libraries. Occasionally, some of our favorite users will pass on to us some suggestion from another library which has appeared in a journal such as the *New England Journal of Medicine*; for example, an item from Glover Memorial Hospital, Needham Mass.

This library, in order to discourage theft of books and just plain failure to return library books, painted a colored line around the cover of each book. Now they have had no loss of books and borrowers are returning hospital library volumes more promptly. (NEJM 288, no 14, Apr 5, 1973, p 743).

Another letter commented on correspondence of S K Zimmer and Gillian Olechno (NEJM, v 288, no 3, p 165) recommending that hospital libraries be staffed by fully trained "professional" librarians. Dr Zimmer's letter may infer that all staff members of a hospital library be professionally trained, but I feel sure his meaning was that the library be under the direction of a trained librarian. Obviously, small hospitals, and even some not so small, cannot afford a full staff of graduate librarians. Many hospital libraries function very efficiently under the supervision of a chief librarian who is professionally trained — sometimes with volunteers who may or may not have library training or experience, sometimes with qualified subprofessional assistants.

And how can we say that patient care doesn't suffer if you lack a library well stocked with the appropriate texts and journals to supply the needs of all departments? Help is available, of course, from the resource libraries in the area and the National Library of Medicine, but in emergency cases this sometimes requires too much time. Also, a CORE library doesn't necessarily provide adequate information in unusual cases and the professionally trained medical librarian

is versed in the sources of informational materials her hospital staff needs most. After all, book and media selection for a library demands professional expertise both on the part of the physician and the librarian.

The suggestion that the medical records librarian, a misnomer originally, and now changed to "administrator," be the staff librarian also, is ridiculous. There is no relationship between the two positions, even though both require graduate study to obtain an academic degree. How many of these people have found themselves saddled with a medical staff library to operate in addition to their own full-time job?

As more librarians graduate from our library schools, it should become easier for hospitals to find professional librarians who can efficiently supervise a staff composed of capable clerical and general assistants. When JCAH decides to examine hospital libraries carefully and consequently elevate standards, hospitals can be required to improve staffing criteria as well as book and journal collections.

Quoting from *Standards for Library Services in Health Care Institutions*,¹ it states in the introduction: "A qualified competent professional librarian is the key to any successful program of library service."

Also, "Where the level of need for service does not require the full-time employment of a professional librarian, the following should be considered: 1) the use of consultant service or supervisory personnel, 2) the pooling of resources and the sharing of services by two or more health care institutions in a geographic area, and 3) service supplied through a regional library system."

1. Association of Hospital and Institution Libraries. Hospital Library Standards Committee. *Standards for library services in health care institutions*, 1970.

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Medline

The terminal is operational and by now you should have specific instructions for requesting bibliographic searches; we expect to hear from all members of Med-Chi, as well as any other individuals or groups in the metropolitan and state medical community.

Recently, we were informed that there might be a charge for connect time, that is, actual time required to complete a machine search. Originally this was not contemplated, but many changes are being made in HEW these days. For the time being we expect not to charge for searching time, however.

Mr Joseph Jensen spent three long weeks at National Library of Medicine in a concentrated course for Medline analysts. He will be glad to help you work out your search formulation.

NEW ACCESSIONS - BOOKS (Arranged by Subjects)

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- Ref. American Medical Association
WB **Topics;** information on significant programs and
1 issues in health care. Jean Breivogel, Chicago,
.AA1 1972.
.A5
Ref. **The International who's who.** London, Europa
CT publications ltd, 1972.
120
.15

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- WD International Congress of Allergology, 7th Flor-
300 ence, 1970
.16 **New concepts in allergy and clinical immuno-**
logy. Amsterdam, 1971.
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300 Diseases
.N2 **Allergy research,** an introduction. US Govt
Print Off, Washington, 1972.

BACTERIOLOGY

- QW Joklik, Wolfgang K
4 The historical development of medical microbiology, 15th ed. New York, Appleton-Century-Crofts, 1972.
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DENTISTRY

- WU Gardner, Alvin F
290 Pathology of oral manifestations of systematic diseases. New York, Hafner, 1972.
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EMBRYOLOGY

- QS International Symposium on the Effect of Prolonged Drug Usage on Fetal Development, Kefar Sava, Israel, 1971. Drugs and fetal development; proceedings. New York, Plenum Press, 1972.
675
.U5

GASTROINTESTINAL SYSTEM

- WI Cocco, Arthur E
100 Training manual in gastroenterology, 4th ed.
.C7 Baltimore, 1972.

GERIATRICS

- WT Aging and the brain. New York, Plenum Press, 1972.
150
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7 Collected reprints, 1927-52.
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HOSPITAL ADMINISTRATION

- WX Griffith, John R
157 Quantitative techniques for hospital planning and control. Lexington Mass, Lexington Books, 1972.
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INFECTIOUS DISEASES

- WC Australia antigen and hepatitis. Cleveland, CRC
536 Press, 1972.
.A9

MEDICAL PROFESSION

- W American Academy of General Practice. Committee on Medical Economics
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.A5 Organization and management of family practice. Kansas City Mo, 1968.
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- WE Daniels, Lucille
500 Muscle testing, 3d ed. Philadelphia, Saunders,
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172 Orthopedic appliances. London, Faber & Faber, 1972.
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- WL 102 .S85 **Steroid hormones and brain function.** Berkeley, Univ of California Press, 1971.
- WL 307 .S9 **Symposium on the Neurobiology of the Amygdala,** Bar Harbor Me, 1971
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Risks in the practice of modern obstetrics. St Louis, Mosby, 1972.
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The death peddlers: war on the unborn. Collegeville Minn, St John's Univ Press, 1971.
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Changing hospital environments for children. Cambridge Mass, Harvard Univ Press, 1972.
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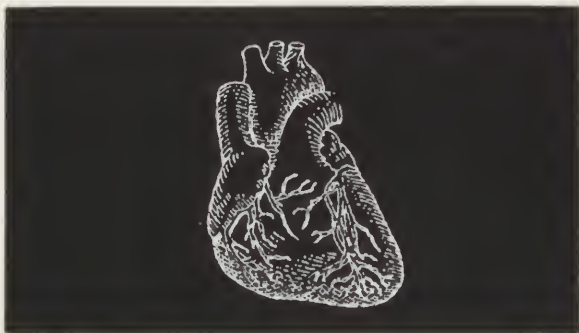
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the heart page

CONGENITAL HEART DISEASE IN THE NEWBORN

PART 1: RECOGNITION AND DIAGNOSIS

DANIEL R PIERONI MD
ROBERT L GINGELL MD

Dr Pieroni is Assistant Professor of Pediatric Cardiology, Johns Hopkins University School of Medicine. Dr Gingell is a Fellow in Pediatric Cardiology at Johns Hopkins.

Supported in part by the Maternal and Child Health Service Project Grant 12 H201 and from the Department of Pediatrics, Johns Hopkins Medical School and Johns Hopkins Hospital, Baltimore Md 21205.

Introduction

The highest mortality rate for congenital heart disease occurs within the first month of life. Close examination of this group of unfortunate infants reveals that most of them die in the first week. If the physician is to alter these statistics at all, he must concentrate his efforts upon the newborn.

In many instances it is imperative to reach a prompt diagnostic decision before the infant catastrophically deteriorates into irreversible congestive heart failure. Early recognition of the presence of congenital heart disease invariably leads to increased survival rates since it brings the child closer to proper medical and surgical management. A long delay in appreciating the presence of congenital heart disease further deteriorates an already compromised neonate. It is, therefore, our hope to provide useful information to the physician for the early recognition and diagnosis of congenital heart disease in the newborn period.

Recognition

The three most common reasons for referring an infant to the cardiologist are:

- 1) Congestive heart failure
- 2) Cyanosis
- 3) Presence of a murmur

Analysis of these three areas is extremely helpful in learning to recognize and diagnose the presence of congenital heart disease.

Congestive Heart Failure

Frank congestive heart failure is usually preceded by subtle but rather consistent signs. Mothers frequently relate that their infants nourish and thrive poorly, requiring 30 to 45 minutes to complete the usual 3-oz feeding and often lapse off to sleep, exhausted. At this time the mother may note an increased respiratory rate and diaphoresis.

The pulse and respiratory rates gradually increase and a gallop rhythm heralds the onset of congestive heart failure which invariably becomes manifest with four cardinal signs:

- 1) Tachypnea
- 2) Tachycardia
- 3) Hepatomegaly
- 4) Cardiomegaly

A respiratory rate above 50 and a pulse rate above 150 beats per minute in an infant should always be considered abnormal. It is not unusual to find the respiratory rate in the range of 80 to 100 per minute and the pulse rate between 150 and 200 beats per minute with failure. Soft grunting expiratory efforts indicate the presence of dyspnea.

A liver edge 1 to 2 cm below the costal margin is a normal finding in the newborn. Palpation of the edge 3 to 4 cm or more below the costal margin should indicate hepatomegaly. Cardiomegaly exists when the cardiothoracic ratio on chest radiogram exceed 55%. Although clinical signs may occasionally indicate the predominance of either right or left sided failure, usually the infant presents with combined failure.

Congestive heart failure tends to develop in different congenital lesions at specific times. Although there may be considerable overlap among these defects, Table 1 indicates the most likely time of onset for congestive heart failure.

Table 1: Congestive Heart Failure in the Neonate

Birth — 1st week
Hypoplastic left heart syndrome
1st-4th week
Hypoplastic left heart syndrome
Coarctation of the aorta
Transposition of the Great Vessels
1st-3rd month
Coarctation of the aorta
VSD
PDA

Cyanosis

Since many normal newborns have circumoral grayness and acrocyanosis, it is often difficult to determine whether or not a child is actually cyanotic. This is especially true if the child is black, plethoric, or cold. The oral mucosal membranes are the best areas to evaluate cyanosis clinically. Accurate determinations are now possible with blood gas calculations on arterial samples. Once noncardiac causes have been eliminated and true cardiac cyanosis established, this sign should always be regarded with respect since it indicates the presence of serious congenital heart disease.

Cyanosis also tends to develop in onset and intensity in specific congenital lesions at characteristic ages. The most severe cyanosis at birth is seen in patients with tricuspid or pulmonary atresia, while moderate degrees are observed at birth or during the first week in infants with transposition of the great vessels and pulmonary atresia with a ventricular septal defect. More obvious cyanosis develops gradually throughout the first six months in children with total anomalous pulmonary venous return, truncus arteriosus, and tetralogy of Fallot. The latter defect notoriously produces cyanotic "spells" starting around the fifth or sixth month of life.

Murmur

The presence of a murmur and its intensity has little correlation with the severity of congenital heart lesions in the newborn period. In fact, 30% of all patients with transposition of the great vessels have no murmur. The time of onset of the murmur, on the other hand, may indicate the presence of specific lesions. This relationship depends on neonatal hemodynamics, specifically persistence of high pulmonary resistance. Left-to-right shunts will not produce a murmur until the pulmonary resistance begins to recede. This is the reason why the typical holosystolic murmur of a VSD is not noted at

birth. Outflow lesions, such as aortic and pulmonary stenoses, do not depend on lowered pulmonary resistance and therefore produce characteristic harsh ejection murmurs at birth.

The typical continuous murmur of a patent ductus arteriosus depends not only on the pulmonary resistance but also ductal tone. Atrial septal defects rarely produce murmurs in the newborn period. One of the most common murmurs, that of relative peripheral pulmonary stenosis, is characterized by bilateral harsh ejection murmurs radiating to both axillae. If the murmur itself is neither typical of a specific type of lesion nor its severity, it is of little practical value other than to alert the physician of underlying heart disease.

Diagnosis

Before one embarks on a differential diagnosis of congenital heart lesions in the neonatal period, he should seriously consider the statistical possibilities. It is virtually impossible to obtain accurate incidence data of specific defects since some lesions go undetected, and others uninvestigated. The two classical methods of compiling this information utilize either autopsy reports of children dying of congenital heart disease during the first month of life or records of those patients who undergo cardiac catheterization during the same interval. The former method considers ultimately fatal lesions and the latter tends to include the more serious lesions. Nonetheless, these are the infants who are at risk and require maximum medical attention for survival. A combination of both methods reveals nine congenital heart lesions which comprise over 80% of the most serious cardiac defects found in infancy.

Table 2

Hypoplastic Left Heart Syndrome
Coarctation of the Aorta
Transposition of the Great Vessels
Hypoplastic Right Heart Syndrome
Tetralogy of Fallot
Truncus Arteriosus
Endocardial Cushion Defect
Ventricular Septal Defect
Patent Ductus Arteriosus

The hypoplastic left heart syndrome may be defined as a severely underdeveloped or atretic ascending aorta, miniscule left ventricular cavity, and mitral annulus. Clinically, the patients rarely have gross cyanosis at birth but develop tachypnea followed by congestive failure within the first few days of life. Auscultatory findings are diagnostically unrewarding except for a single second sound. Ductal blood flow may support a normal pulse pressure or generalized collapse of the pulses may be found with congestive

failure. The electrocardiogram has right axis deviation, right atrial and ventricular enlargement, while the chest film shows an enlarged globular heart with engorged lungs. Differential diagnosis includes respiratory distress syndrome and transposition of the great vessels. The former rarely has such marked cardiomegaly and the latter usually has more left ventricular forces on ECG. Symmetrically normal or decreased pulses distinguish this syndrome from a coarctation of the aorta which has a discrepancy between upper and lower-limb pressures.

Coarctation of the aorta classically has been divided into preductal (infantile) and postductal (adult) types. The preductal type is frequently associated with other cardiovascular defects; the most common are patent ductus arteriosus and ventricular septal defects.

Coarctation of the aorta is the most frequent cause of congestive heart failure in the newborn period. Clinical recognition of this defect is relatively simple and should never be overlooked if the femoral and brachial pulses are carefully examined in every infant. Hemodynamics dictate normal or elevated upper extremity pressures in the face of diminished or absent pulses in the lower limbs. Occasionally, the left brachial pulse will also be dampened when the left subclavian artery is involved in the coarcted segment. Auscultation may reveal nothing more than a soft ejection systolic murmur. The chest film demonstrates moderate enlargement of the cardiac silhouette with prominent pulmonary vascular markings. The electrocardiogram usually has right ventricular hypertrophy. Since isolated coarctation of the aorta is rare by itself, one should always search for associated lesions.

In **transposition of the great vessels**, the aorta arises from the right ventricle and the pulmonary artery from the left ventricle. This arrangement produces a state of persistent cyanosis, the intensity of which is dependent on whether or not there are associated shunt lesions. Besides cyanosis, the most frequent finding in the newborn period is congestive heart failure. In the absence of a VSD, auscultation is unremarkable except for a single second sound. The electrocardiogram has right axis deviation and moderate right ventricular hypertrophy. The presence of left ventricular forces differentiates this defect from a hypoplastic left heart syndrome. The classic chest X-ray description includes an egg-shaped heart with a narrow base and marked pulmonary plethora. The latter finding differentiates the transposition defect from a tetralogy of Fallot which has pulmonary oligemia.

Hypoplastic right heart syndrome consists primarily of pulmonary atresia with a small or diminutive right ventricle and hypoplastic tricuspid ring. Persistent cyanosis progressively deepens throughout the first week. Careful observation will reveal prominent "a" waves in the neck. Over half of these infants develop significant right heart failure. Auscultation reveals a single second sound, occasionally a continuous murmur of a PDA and, less frequently, a high frequency tricuspid insufficiency murmur. The chest film demonstrates a large heart with decreased pulmonary vascularity. The EKG has a normal axis, right atrial enlargement and left ventricular hypertrophy. This latter finding differentiates it from a tetralogy of Fallot with pulmonary atresia. Patients with tricuspid atresia usually have a small heart with left axis deviation on the electrocardiogram.

The **tetralogy of Fallot** consists of two primary defects: a subaortic ventricular septal defect and infundibular pulmonary stenosis. The clinical course of this defect depends largely on the progression of infundibular narrowing. The greater the degree of obstruction, the more serious the defect. Cyanosis, infrequently pronounced at birth, deepens with increasing stenosis. Likewise, the classic harsh ejection murmur of infundibular stenosis tends to diminish on narrowing and disappears during "cyanotic spells." Splitting of the second sound may be auscultated when the obstruction is mild but becomes single with progressive narrowing. Congestive heart failure is unusual and presents only when the infundibular stenosis is so mild that it does not retard left-to-right shunting across the ventricular septum. The chest film usually reveals a normal-sized heart with decreased vascularity. A right aortic arch is seen in 30% of cases. The EKG has right axis deviation and right ventricular hypertrophy.

Truncus arteriosus consists of a single great vessel from which the pulmonary arteries arise. A large ventricular septal defect is always present. Intermittent cyanosis is a common finding, while congestive heart failure develops late. Because of the large runoff to the pulmonary arteries, the pulses are often bounding. The second heart sound is usually very prominent and single. Although a variety of murmurs may be present, the most diagnostic is an early diastolic murmur of truncal insufficiency. The chest film demonstrates a moderately large heart with increased pulmonary vascularity. Fifty per cent of the cases have a right aortic arch. The EKG has a normal axis and biventricular hypertrophy with a prominent left-ventricular component.

Ventricular septal defects are the most common

of all congenital heart defects. Anatomically they vary in size and position, and may be isolated defects or associated with complex malformations. Tachypnea is almost always present in significant defects; failure is unusual during the first two weeks of life. A loud, early systolic murmur—typically noted on the second and third days—gradually becomes pansystolic by the fourth week. A mild diastolic mitral flow murmur may develop with increased shunting. The pulses are usually normal. With significant shunts, the EKG demonstrates biventricular hypertrophy; the chest film shows an enlarged heart with increased pulmonary vascularity.

A patent ductus arteriosus can be differentiated from a ventricular septal defect on the basis of some rather characteristic findings. A classic continuous or late crescendo systolic murmur in a patient with bounding pulses should always alert the physician to the possibility of a PDA. Tachypnea and congestive failure follow a similar pattern to the ventricular septal defect. The electrocardiogram and chest roentgenogram may be inseparable. A history of prematurity or rubella syndrome are clues to the diagnosis of a ductus.

The complete form of an endocardial cushion defect includes confluent atrial and ventricular septal defects with clefts in the mitral and tricuspid valves. The onset of congestive heart failure is early. The precordium is usually hyperdynamic, cyanosis is variable depending on mixing, and murmurs may range from short ejection to pansystolic. The chest film has cardiomegaly with pulmonary plethora. The distinguishing feature of this defect is the left axis deviation on the electrocardiogram which also shows a prolonged PR interval and combined ventricular hypertrophy. In a child with mongolism and congestive heart failure, this diagnosis should always be considered before others.

Conclusions

It is not the purpose of this paper to discuss medical therapy and surgical treatment of infants with congenital heart disease. However, it is the hope of this communication to emphasize that the highest mortality rate for congenital heart disease occurs within the first month of life. Therefore, in order to change these statistics, one should focus his attention upon the newborn. Recognition of the most common signs of congenital heart disease should alert the physician to the presence of underlying heart disease and further aid in determining a diagnosis.

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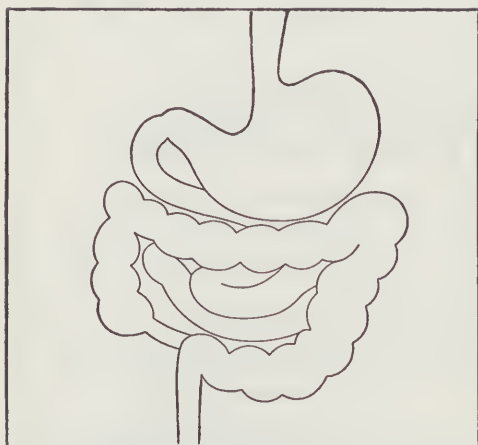
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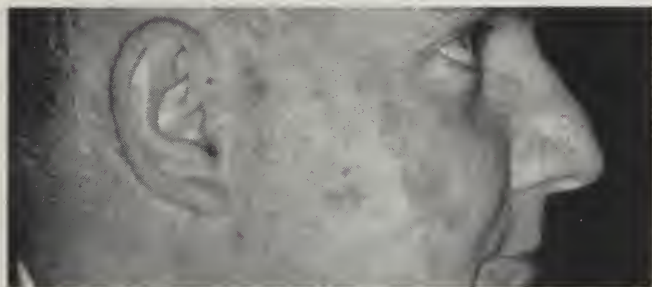
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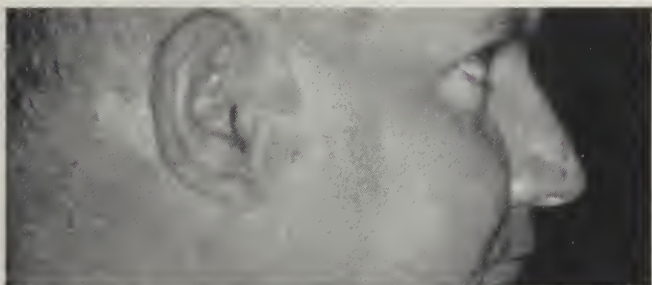
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John Galsworthy

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rehabilitation medicine

THE ROLE OF SPORTS IN REHABILITATION OF THE HANDICAPPED

Part 2B: Functional Levels and Classification of Handicapped Athletes

NORMAN B ROSEN MD

Dr Rosen is Assistant Physician-in-Chief and Director of Rehabilitation Therapies for the Maryland Rehabilitation Center, 2301 Argonne Dr, Baltimore Md 21218. He is also Consultant in Rehabilitation Medicine at Baltimore's North Charles General Hospital and Kernan Hospital for Crippled Children. He is also Instructor in Rehabilitation Medicine at the University of Maryland Medical School.

Information and reprint requests to Dr Rosen.

Paraplegic Competition

It is actually below the level of upper extremity involvement where wheelchair athletics change from the somewhat static sporting activities to the dynamic, fiercely competitive events that have catapulted these games to world-wide attention. The endurance requirements, the skills needed in simply maneuvering a wheelchair, and the determination and persistence required to succeed in head-to-head competition are the very aspects of competitive sport that have traditionally appealed to both athlete and spectator.

From a classification standpoint (Tables 2 and 3), it is at this level where the two major classification systems in use today differ. The United States Classification system lumps all spinal paraplegic patients originated at T9 or above into one class, and calls this Class I, whereas the International Classification System subdivides this group of patients into two subclasses, using T5 as the dividing point. Thus, patients in the International Classification with lesions between T1 and T5 are classified as Class II and those from T5 through T10 are recognized as Class III.

Clinically, one would expect that patients who have all of their intercostal muscles functioning appropriately would demonstrate a better ability for air exchange and oxygen utilization. They would exhibit an improved level of endurance and performance over their less favorably endowed counterparts who have control of only the upper intercostal muscles. Furthermore, the in-

creased amount of functioning musculature, specifically the spinal extensors, permits potentially better trunk balance and stability.

Obviously, in events such as swimming where endurance plays an important role, the difference in breathing would be significant. In activities requiring strength and balance, where trunk control is essential in providing the central stability required for more powerful upper extremity movement, a similar difference would be noted. Thus it would seem that by dividing this disability group into two sub-groups the International System is more equitable than the United States Classification System.

Classification, Low Paraplegic Athlete

Below the level of T10, the two classification systems again differ significantly from several standpoints, while the United States system (Class II) extends through L2, the corresponding International Class IV includes patients whose level of injury occurred as low as L3. Furthermore, in addition to these classifications for complete spinal-cord lesions, the United States Class II also includes "other disabilities where there is significant loss of muscular function at the hips and thighs" whereas, in contrast, the International System assigns a point score to any muscle function present in either lower extremity. This is particularly important in grading the lower levels of spinal-cord involvement and, even more important, in grading incomplete spinal cord injuries, poliomyelitis, and other disabilities where the lower extremities are weaker than normal. Thus, the existing muscle function in the lower extremities is graded on a ten-point scale relative to the degree of normalcy present at the hip, knee, and ankle (maximum value is ten points per normal joint or a total of 30 points per normal extremity).

There has been some controversy relative to the assignment of equal point grades to hip-and-ankle function as is currently being done

under the International System. Many have argued that the hip plays a more important role in wheelchair athletic competition than does the ankle and should thus be accorded a greater proportion of points in the grading. The merits of such a suggestion appear to be well-founded.

The International Class IV allows competitors with up to nine points. With ten or more points, the International System has set up a **Class V**, which allows up to a maximum of 29 points. With even more active lower extremity function, a **Class VI** includes incomplete paraplegics with 30 to 50 points, or amputees and polio patients with 30 to 45 points. Indeed, at the recent World Games in Heidelberg, an amended and expanded point assignment was proposed and adopted for use in 1974 (Table 4).

Table 4: Revised International Classification

- IA, IB, II, III: No change
- IV: Competitors without quadriceps or with quadriceps strength sufficient only to overcome gravity, and with gluteal paralysis
- V: Muscle function in lower extremities 10 to 39
- VI: Muscle function in lower extremities 40-60 (paraplegics) or 40-50 (polios)

The proposed new classification grants a total of 20 points to hip function (five for hip flexion, five for hip extension, five for hip adduction, and five for hip abduction). Knee flexion and knee extension each merit five points and ankle dorsiflexion and plantar flexion are also accorded five points each. Thus a normal extremity is worth 40 points instead of 30. Furthermore, points are scored on a zero-to-5 basis with zero meaning a total lack of voluntary contraction, two indicating a voluntary movement possible only with gravity eliminated, four meaning movement possible against mild resistance and gravity, and five indicating the presence of a voluntary contraction allowing movement against strong resistance (Table 5). Similarly, the points allowed for each class have been increased (Table 4).

Table 5: Testing Points System

- 0: Total lack of voluntary contraction
- 1: Faint contraction without any effect on mobility of joint
- 2: Voluntary contraction producing movement only with gravity eliminated
- 3: Voluntary contraction producing movement against gravity only
- 4: Voluntary contraction producing movement against gravity and against mild resistance
- 5: Voluntary contraction able to overcome strong resistance

The United States Class III corresponds to these least severely involved classes and consists

of "all other disabilities below L2." Obviously, this class is a broad one and includes a wide range of disabilities.

L2-L3 Level Significance

The significance of the division into different classes at the L2-L3 level is best understood when one recalls that it is at the L3 level that, in addition to the hip flexors, the hip adductors and knee extensors are beginning to be innervated. The hip flexors (iliopsoas) are actually innervated completely (L1-L3) at this level, as are the sartorius, the pectineus, and adductor longus (L2-L3). The gracilis and adductor brevis are partially innervated (L2-L4) and the important quadriceps have received a significant portion of its innervation, thus providing the athlete with active knee extension.

With the appearance of significant two-joint function as a result of L3 innervation, the merits of using a point system to determine classification becomes apparent. The United States System of using L2 as its dividing point is based on the fact that although the muscles of the two joints (hip and knee) are partially innervated, knee extension is generally not significant at this level. It would appear that the difference in active knee extension allowed by an intact L3 nerve root might be significant in competition in sports such as swimming. Relative to wheelchair competition, however, this difference would be less apparent.

Other Disabilities

When other disabilities are involved, the classification system has come under a great deal of fire and controversy. For example, the patient with cerebral palsy may have virtually normal strength and active range of motion in all his joints. Because of either spasticity or athetosis, however, he is unable to control his movements and lacks the necessary speed of reaction which is inherently required in sport participation. In fact, although a person with cerebral palsy may participate in organized wheelchair games in the United States, in England he is not permitted to compete. Suggestions have been made to set up special events within the scope of the games or to establish separate games for this type of disability.

Muscular Dystrophy is another specific disability where the classification system has proved to be somewhat inadequate. Because of the proximal shoulder and hip girdle weakness, this athlete is difficult to put into any specific group on the basis of the classifications currently in use.

Similarly, difficulties have arisen in the classification of patients who have patchy patterns of

**Table 6: Significant Levels of Function
(Trunk and Lower Extremities)**

- T6: Upper intercostals
- T11: Lower intercostals
 - Spinal extensors
 - Abdominal muscles (muscles of expiration)
- L2: Hip flexion (fair to good)
 - Hip adduction
 - Trunk stability (good)
- L3: Knee extension
- L4: Hip abduction
 - Knee flexion (partial)
 - Ankle dorsiflexion (fair)
 - Foot inversion (partial)
- L5: Hip extension
 - Foot eversion
- S1: Ankle plantar flexion (fair to good)

muscular dysfunction, such as the patient with poliomyelitis or the one with an incomplete cervical spine injury.

The participation of amputees in wheelchair games is another area where much difference of opinion and practice exists. At the present time, the amputee may participate in competitive events in the United States and in the Pan-American Wheelchair Games; however, he is barred from competition in the Stoke-Mandeville Games and the Paralympics.

Other Areas of Controversy

Other areas of controversy exist relative to grading of spasticity, spinal fusion, and bracing.

Spasticity in the upper extremity is a major factor which interferes with the dexterity normally required for adequate performance. Spasticity itself is a variable factor, even in the same individual. It is influenced by a wide variety of factors, including physical exertion, bladder infection, temperature, body position, and emotion. The implications for participation in athletic competitive events are apparent. It has been stated that in events such as swimming, spasticity is a negative factor, causing increased drag and increased tendency to sink. Currently, the present policy relative to spasticity is to note its presence or absence but to disregard it when classifying any particular patient.

Spinal fusion is another area of controversy, particularly in the polio patient where the presence of a fusion might allow a greater area of function to come within the scope of the participant's existing musculature. This may also be true in considering the abilities of the patient with a spinal cord injury who has undergone an extensive fusion.

Bracing and the use of other appliances are other factors that the classification teams must

take into consideration in placing any competitor into a specific class. Since braces are designed to improve function, an athlete using such a device might be placed into a higher classification than he normally would be, based on his existing musculature. On the other hand, one must remember that although an athlete may function at a higher level with braces or other appliances, the additional weight, even with light-weight braces, may impair his performance from an endurance standpoint.

"Ability, Not Disability"

Obviously, any classification system is, by definition, arbitrary and subject to a great deal of controversy.

One must keep in mind, however, that these systems were devised to allow more fairness in determining levels of competition among a large spectrum of disabilities and that, in the last analysis, the purpose of the Games is to provide an arena for active, healthy competition among a group of participants who normally would be deprived of the pleasures, exposure, and rewards of such participation by the very fact of their being disabled. In these events, as in life, the emphasis is on Ability rather than Disability.

To be continued

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I hereby authorize my Attorneys to pay, and I assign from the proceeds of my recovery, such amounts as are necessary to pay for your professional services, related medical expenses incurred by me, and fees for the preparation of reports and testimony and for testifying as a result of the matter hereinabove stated. I understand and agree that nothing herein authorized relieves me of the primary responsibility of paying you for the services rendered to me. In the event of a dispute as to the charges for your services, my Attorneys are directed to withhold the full amount of your bill until the matter is resolved by agreement or judgment.

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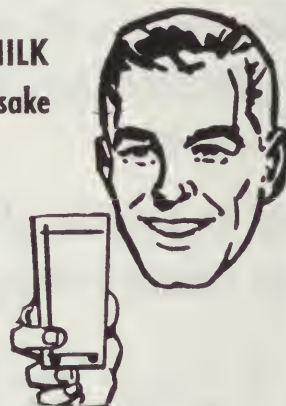
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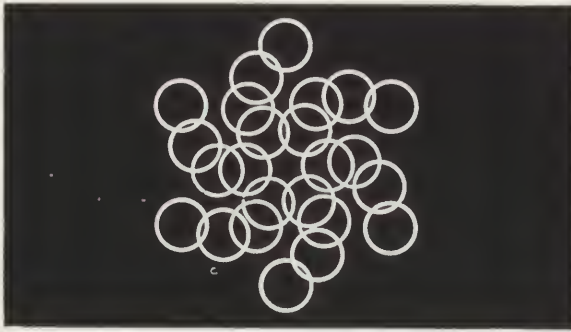
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From the Subcommittee on Alcoholism of the
Medical and Chirurgical Faculty of the State
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alcoholism section

Bedside Manner: For Better or Worse

SIDNEY WOLF PhD

Dr Wolf is Chief, Division of Alcohol Abuse & Alcoholism, Bureau of Mental Health, Baltimore County Department of Health. He was formerly with the Maryland Psychiatric Research Center.

This paper was presented at the 23rd Annual Meeting of the Alcohol and Drug Problems Association of North America.

The author extends thanks to these individuals for their help in the execution of this study: Albert Kurland MD, Sanford Unger PhD, and Walter Pahnke MD.

An extensive body of information indicates that counseling, psychotherapy and, in fact, all human relationships are for better or worse (Carkhuff and Berensen, 1967). Studies have indicated that there are individuals who are effective in human interactions and are especially competent at helping other people in distress. There are those, too, who are ineffective in interpersonal relationships and are extremely destructive at efforts to help other human beings.

Important research on this matter dates back to 1960 when the efficacy of psychotherapy and counseling was questioned because studies contrasting psychotherapy treated groups with control groups revealed no significant mean differences (Bergen, 1966). It wasn't until it was discovered that the variance of the psychotherapy-treated groups increased that researchers began to examine the data more closely in an effort to discover why more "treated" individuals received extreme scores on criterion measures of improvement than did their control counterparts. The increased variability of the treated groups indicated that some people were getting better and some were getting worse. Further investigation indicated that therapists contributed significantly to this increased variability, ie, therapists were responsible for people getting better or getting worse (Truax & Carkhuff, 1967).

Research designed to contrast effective versus ineffective "helpers" revealed a number of traits which, when present in counselors, resulted in patient improvement but when absent led to client deterioration. These traits and characteristics make up a core of qualities which are present in high functioning individuals regardless of the specific role, discipline, or function they are performing (Carkhuff & Berenson 1967). For example, regardless of whether one is a psychiatrist, psychologist, social worker, nurse, lawyer, supervisor, physician, manager, parent, teacher, etc, if he or she possesses these traits, he or she is effective in interpersonal relationships. Furthermore, whether the counselor's theoretical orientation is Freudian, Rogerian, Existentialist, etc, if he has the characteristics of the effective individual, he will be helpful in his efforts; when he lacks these traits and characteristics, he will be harmful. These counselor traits are correlated with improvement in vastly different populations. Whether one is working with schizophrenics, alcoholics, college counselees, delinquents, or any other definable group, he will be effective if he is high on the therapist variables. These traits and characteristics have also been correlated with a wide variety of criteria of improvement, such as changes in psychological tests, time out of institutions, independent ratings, self ratings, therapist ratings, supervisor ratings, etc.

Moreover, studies indicate that the therapist variables may be measured reliably and validly, usually on five point scales (Carkhuff, 1969). These scales are operationally defined and one may evaluate a helper's performance by reading the transcript of his interactions, listening to audio tapes of his performance, or actually viewing his interactions through one-way mirrors or

on video tape. Ratings made in this way by individuals who are discriminating and perceptive are highly correlated with outcome criteria (Cannon & Carkhuff, 1969). Using these scales, normative data on the population at large has been obtained.

On these rating scales, Level 3 is arbitrarily set as the point of minimal helpfulness, ie, an individual who scores at Level 3 or above is helpful and should achieve statistical outcome rates of improvement in his patients, far exceeding those of low functioning individuals. Sadly, on the average, most people function at Level 2 (Carkhuff & Berenson, 1967). Thus, it is rare in life to find anyone who can provide even minimally facilitative conditions and who is helpful. Furthermore, experienced counselors and psychotherapists function, on the average, at about Level 2. Even when one is desperate enough to pay money to obtain help, one may obtain a low-functioning therapist who is destructive. Graduate clinical psychology students entering their programs, on the average, function at Level 2.5, a quite satisfactory beginning level which suggests a potential for growth. However, later in their training these individuals drop to Level 2 (Carkhuff & Berenson, 1967). Thus, it seems that often we train out the best qualities and characteristics of our potentially most helpful students. In a study where people were asked to give a list of individuals to whom they would turn in time of need and a list of people to whom they would not turn when in distress, independent measures of these individuals' helping abilities revealed that people turn to those who have naturally therapeutic personalities and refrain from contacting those who are low functioning. (Carkhuff & Berenson, 1967).

Variables

The variables which have been measured, defined, and which separate high and low-functioning individuals are the following:

Empathy

Empathy (Carkhuff, 1969) is the ability to accurately perceive what another person is experiencing and communicate that perception. At high levels of empathy, an individual adds noticeably or significantly to the communication, while at low levels, the individual detracts noticeably or significantly from the communication.

Respect

Respect implies that a helper appreciates the dignity and worth of another human being. It also implies that the helper accepts the fact that each individual has a right to choose, possesses free will, and may make his own decisions. Respect also indicates that each individual has the

inherent strength and capacity for making it in life. At low levels, a person functioning without respect may overprotect, be condescending, or even hold another in low esteem or negative regard. He may make decisions, give advice, be falsely reassuring, or be hostile.

Genuineness

Genuineness (Carkhuff, 1969) is the ability of an individual to be freely and deeply himself. It is nonphoniness, nonrole playing, nondefensiveness. A person who is genuine is congruent; there is no discrepancy between what he is saying and what he is experiencing. At low levels of genuineness a person may say one thing and communicate another nonverbally. He may be stiffly "professional" or be playing a role (rather than fulfilling a role). He may seem very different in the therapy room from what he is normally. People who function low in genuineness hide behind a facade.

Concreteness

Concreteness (Carkhuff, 1969) implies specificity of expression concerning the client's feelings and experiences. The concrete therapist keeps communications specific and gets to the what, why, when, where, and how of something. Notions, thoughts, and experiences are explored in depth. The concrete therapist maintains relevancy in the communication and prevents the client from avoiding or escaping from the issues at hand. A low-functioning therapist who is not concrete is abstract or general. He is very permissive and allows the client to explore irrelevancies, to get off on tangents, and to maintain himself at an abstract level.

Confrontation

Confrontations (Berenson, Mitchell & Taney, 1969) occur when there is a discrepancy between what one is saying and what he is experiencing, or between what one is saying at one point and what he has said before, or between what one is saying and what his actions imply. This variable is totally under the control of the therapist and is initiated when the therapist feels it is appropriate. Confronting is risky and can precipitate a crisis, but it is often through such crises that the beginning of true growth occurs both in the therapeutic relationship and in the client's life. There are different kinds of confrontations possible in a counseling situation. For example, an experiential confrontation is a confrontation that occurs in the here and now, usually because what the client is saying and what he is experiencing are not congruent. There may be strength confrontations, when the therapist emphasizes a client's strength in the face of the client's communicated feelings of weakness.

Weakness confrontations occur when the client is ostensibly presenting strength, but in fact, there are difficulties to be resolved and the client is avoiding them. There may be action confrontations when the therapist encourages the client to take action, or didactic confrontations when the therapist transmits factual information.

Self-disclosure

Self-disclosure (Carkhuff, 1969) is the revealing of personal feelings, attitudes, opinions and experiences on the part of the therapist for the benefit of the client. The therapist, during self-disclosure, exposes himself and shares with the client some meaningful self-disclosing statements which may be pertinent to the issues. At low levels, the therapist never reveals himself, and maintains a screen of neutrality. Self-disclosure must be used with discretion and an accurate sense of timing and appropriateness. In all cases, self-disclosing statements should occur for the client's sake and not for the therapist's own catharsis.

Immediacy

Immediacy (Collingood & Renz, 1969) is dealing with the feelings between the client and the counselor in the here and now. A high level of immediacy exists in the open discussion and analysis of the interpersonal relationship occurring between the client and the counselor within the counseling situation. This is a very important variable because it provides the opportunity to work out problems and difficulties in an ongoing relationship so that the client profits from the experiences. The client can learn to restructure his interpersonal relationships by finding that it is possible to confront, to reveal oneself, and to express negative or positive emotions to another human being quite safely. Thus, the counselor who is immediate feels comfortable engaging in explorations of the present relationship existing between the client and himself.

Potency

Potency (Wolf, 1970), is charisma; it is the dynamic force and magnetic quality of the therapist. The potent therapist is one who has a force of presence. He is obviously in command of himself and communicates to others his sense of competence and security. The person who scores low in potency is milque-toastish, flat, a nonentity. He has little dynamism, little inner power. Such a person cannot evoke feelings of security; rather one feels uneasy in the presence of such an individual and would be reluctant to trust or burden him.

Self-actualization

Studies have indicated that self-actualization is highly correlated with success in counseling

(Foulds, 1969). That is, therapists who are themselves self-actualized serve as models of effective people who can live life fully and successfully. Self-actualization implies that one can live and meet life directly. A self-actualized person is one who whose pleasure-to-pain ratio is in the direction of pleasure. Though self-actualized people feel stress and tension, they are not incapacitated by these negative forces. Self-actualized individuals can live in the present and are primarily inner-directed. They are able to express themselves freely and openly. Their values are flexible for these people are not judgmental or moralistic. Self-actualized people have the capacity for warm, intimate contact and in general, are extremely effective at living.

Method and Procedure

In order to test the hypothesis that counselors, according to their level of functioning, differentially affect client outcome, the following experiment was carried out. At Spring Grove State Hospital in Baltimore, controlled studies testing the efficacy of LSD-assisted psychotherapy have been conducted. In these investigations alcoholics were screened, psychologically tested, and then randomly assigned to therapists who worked intensively with the patients for four to six weeks, seeing each patient between ten to 30 hours. Alcoholics were defined operationally as patients hospitalized at the alcoholic rehabilitation unit of the hospital because of excessive and pathological drinking with concomitant destructive emotional and social consequences. Psychotic behavior, brain damage, and drinking were contraindications for inclusion in the study. Screening was done by a five-member staff composed of psychiatrists and psychologists, using case histories, medical records, and psychometrics to decide whether a patient was qualified for the study. The five therapists involved in treating alcoholics included psychiatrists or psychologists, all highly qualified academically and professionally. After screening and psychotherapy, the patients were exposed to drug treatment—either a 12-hour high, or low LSD experience—dosage being randomly determined. Patients thereafter were followed up, retested, and then usually discharged from the hospital. Independent raters evaluated the patients before their treatment and again six months subsequent to their treatment. These pre-post ratings of global adjustment were used as the dependent variable. Thus, change in global adjustment was used to determine whether or not patients improved.

The patients in this study were all males and ranged in age from 26 to 59, with a mean of 42. All were from lower middle-class socio-economic

backgrounds as measured by their income and occupational categories. The level of functioning of the therapists was established on the basis of ratings made by judges listening to recorded 75-minute interviews of the therapists with their patients. The two raters who evaluated each interview were highly trained and discriminating and evaluated each tape, rating global level of functioning.

Results

Table 1 presents therapist level of functioning and the percentage of improvement and essential rehabilitation in their alcoholic patients. Improvement indicates that patients received higher posttreatment global adjustment ratings than they had received pretreatment. Essential rehabilitation is defined as the attainment of a score of eight or more on a 10-point scale of global adjustment. An inspection of Table 1 reveals that level of functioning was directly related to percentage of improvement in patients.

Table 1: Therapist Level of Functioning and Percentage of Improvement and Rehabilitation in Alcoholic Patients

Therapist	Level of Functioning	N	% of Improvement at 6 mos*	% Essentially Rehabilitated 12 mos**
1	4.2	32	78	47
2	4.0	12	75	45
3	2.7	12	66	36
4	2.3	28	61	33
5	1.5	28	60	30

* Positive change in global adjustment

** Attainment of rating of 8 or above on 10-point scale of global adjustment

Conclusions

The impact of the therapist on the client is indeed profound. By employing rating scales to measure the core facilitative dimensions, it is possible to evaluate the strengths, weaknesses, and overall level of functioning of treatment personnel who so differentially affect the outcome of their clients. Training programs designed to inculcate these core qualities and which emphasize communication skills have been designed. The author has been developing such techniques, procedures, and materials to be used in clinical skills development. It has been found that in 60-hour programs, trainees can improve their level of functioning by at least one level. The fact that many individuals are functioning as treatment personnel but are less than effective is indeed sobering, but the development of procedures for measuring and improving helping skills hold promise for the counseling field.

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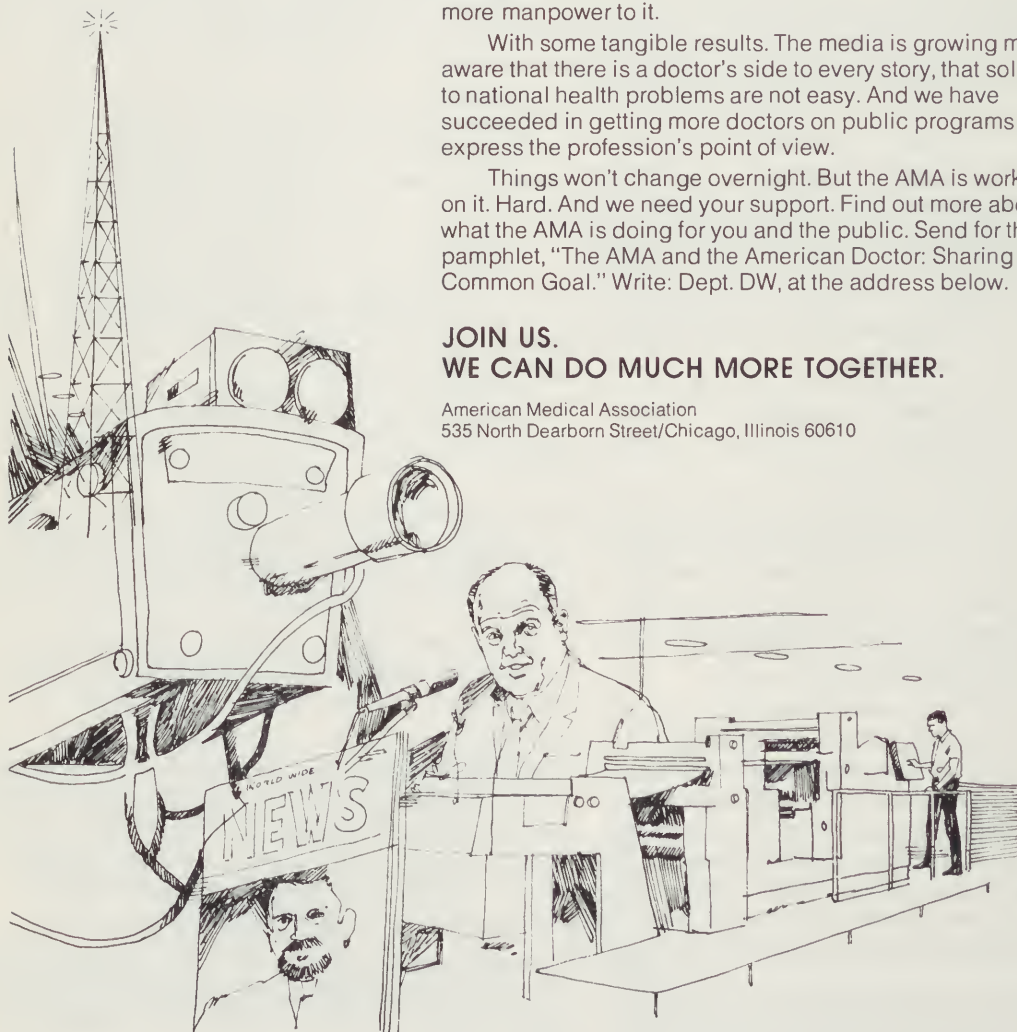
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T ₄ By Column	Less than 3 mcg %	7-9 mcg %
T ₃ (Resin)	Less than 25%	27-35%
T ₃ (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %



AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

Choose the Smooth Road ...to thyroid replacement therapy



Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



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1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyrotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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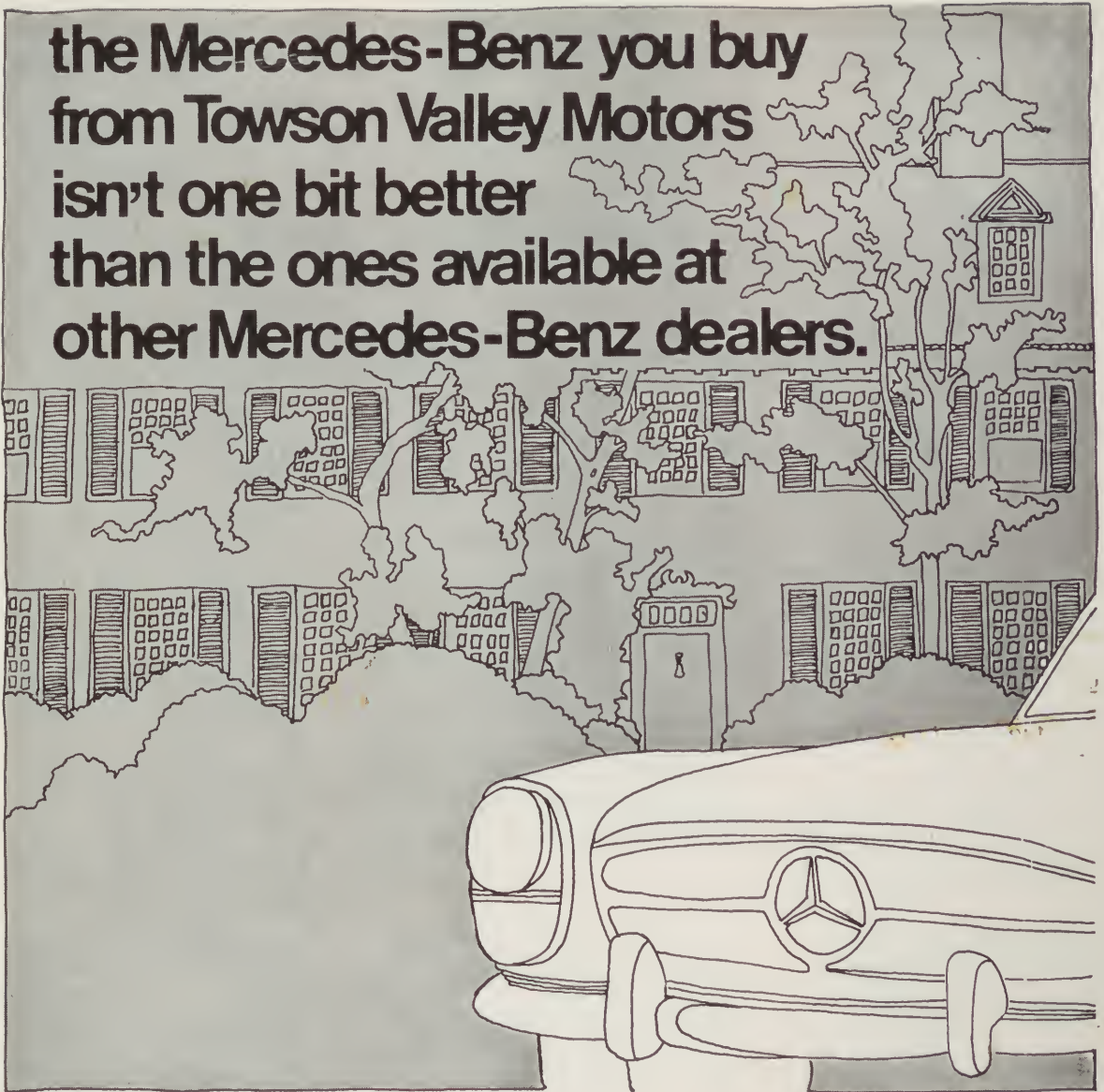
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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JULY 1973

BALTIMORE

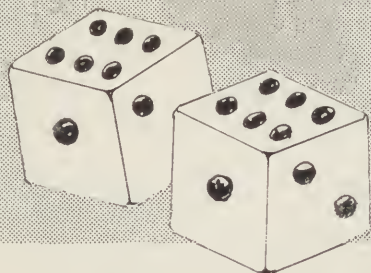
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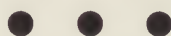
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Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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| Sep | 7 | B-Scan Ultrasound Conf , Johns Hopkins Hosp, Baltimore. Designed for radiologists, obstetricians & nuclear medicine specialists, recently interested in diagnostic ultrasound. Sponsor & info: Dr R C Sanders, Dept of Radiology, Johns Hopkins Hosp, Baltimore Md 21205. |
| Sep | 12-14 | Cancer of Head & Neck , Turner Auditorium, Johns Hopkins, Baltimore. Sponsor: Educational Foundation of American Society of Plastic & Reconstructive Surgeons. Contact: Susan L Clifton, Turner Auditorium, 720 Rutland Ave, Baltimore Md 21205. |
| Sep | 19-23 | Med-Chi Semianl Mtg , Baltimore & Mexico City. |
| Sep | 22-23 | Maryland Heart Assoc , anl mtg, Washingtonian, Route 70-S, Gaithersburg Md. Contact: Heart Assoc of Md, 201 N Charles St, Baltimore Md 21201. |
| Oct | 17-18 | 3rd Biennial Technical Symposium , Mayflower Hotel, Washington. Sponsor & info: Sterile Disposable Device Committee, Health Industries Assoc, 1225 Connecticut Ave NW, Washington DC 20036. |
| Oct | 17-20 | Amer College of Ob&Gyn , Dist III mtg, Cherry Hill Inn, Cherry Hill NJ. Contact: ACOG, 1 E Wacker Dr, Chicago Ill 60601. |

MISCELLANEOUS MEETINGS

- | | | |
|-----|-------|---|
| Jul | 22-27 | 19th Anl Southern Ob-Gyn Seminar , Asheville NC. Contact: Dr Geo T Schneider, Ochsner Clinic, 1514 Jefferson Highway, New Orleans La 70121. |
| Aug | 8-9 | 1st Natl Anl Biomedical Plastics Conf , Roosevelt Hotel, New York City. Sponsor: NY Univ. Contact: Wm A Kulok, 600 Third Ave, New York NY 10016, (212) 687-8540. |
| Aug | 20-23 | American Health Congress , McCormick Place, Chicago. Sponsor & info: American Health Congress, 840 N Lake Shore Dr, Chicago Ill 60611. |
| Sep | 6-8 | Amer Assoc of Ob&Gyn , Hot Springs, Va. |
| Sep | 14-16 | ACR Seminar on the GI System , Amer Col of Radiology, Houston. Info: ACR 20 N Wacker Dr, Chicago Ill 60606. |
| Sep | 17-18 | 33rd Anl Congress on Occupational Health , Benj Franklin Hotel, Philadelphia. Info: AMA Dept of Environmental, Public & Occupational Health, 535 N Dearborn St, Chicago Ill 60610. |
| Sep | 17-21 | Neuroradiology , Harvard Med Sch, Boston. Info: Harvard Med School, Dept of Con Med Educ, 25 Shattuck St, Boston Mass 02115. |
| Sep | 20-21 | Emer Dept Legal Institute , O'Hare Regency Hyatt House, Chicago. Sponsor: ACEP & Hlth Law Cen of Aspen Systems. Info: R T Johnson, ACEP, 241 E Saginaw St, East Lansing Mich 48823. |
| Sep | 27-29 | 2nd Natl Conf on Cancer of Colon & Rectum , Americana Hotel, Bal Harbour Fla. Sponsor: Amer Cancer Society. Info: Dr S L Arje, c/o Amer Cancer Society, 219 E 42nd St, New York NY 10017. |
| Oct | 7-11 | American Society of Anesthesiologists , anl mtg, Hilton Hotel, San Francisco. Refresher crs, scientific sessions, college exams. Contact: ACS 515 Busse Highway, Park Ridge Ill 60068. |
| Oct | 11-13 | 12th Anl Cardiovascular Symposium , Colony Inn, Williamsburg Va. Sponsors: Council on Clinical Cardiology, American Heart Assoc. Contact: Tidewater Heart Assoc Inc, 891 Norfolk Square, Norfolk Va 23502. |
| Oct | 11-13 | American Society for Colposcopy & Colpomicroscopy , 6th clinical mtg & international symposium on colposcopic terminology. Sonesta Beach Hotel, Key Biscayne Fla. Contact: ASCC Symposia International, PO Box 580, Tujunga Calif 91042. |
| Oct | 15-19 | American College of Surgeons , 59th anl clinical congress, Chicago. Includes 16 postgrad crs. Sponsor & contact: ACS, 55 E Erie St, Chicago Ill 60611. |

your medical faculty at work

**by John Sargeant,
Executive Director**

The Council met on Friday, April 27, 1973 and took the following actions:

1. Elected William G Speed III MD, Baltimore, as Chairman; and Arthur T Keefe Jr MD, Chestertown, as Vice Chairman.
2. Elected Aris T Allen MD, as Second Vice President to fill the unexpired term of Manning W Alden MD, who was chosen President-elect by the House of Delegates. Both physicians are from Annapolis Md.

The Council met on Wednesday, April 25, 1973 at the Baltimore Civic Center and took the following actions:

1. Adopted Standards for Therapeutic Abortions (in the first trimester) with the understanding that a public hearing for all members and interested parties would be held during May 1973, and that legal counsel will approve them in final form.
Should any substantive changes occur in these standards, they will be resubmitted to Council for final approval.
2. Deferred, until the June 1973 Council session, consideration of Bylaw amendments proposed by the Maryland Foundation for Health Care Board of Directors.
3. Expressed appreciation to retiring Council members and to the Chairman for his work during the past year.

The House of Delegates met on Wednesday, April 25, 1973 at the Baltimore Civic Center and took the following actions:

1. Accepted the minutes of the House of Delegates Semiannual Session, Saturday, Sept 15, 1972.
2. Observed a moment's silence in memory of deceased colleagues.
3. Honored 50-year members by presentation of certificates and 50-year pins.
4. Elected the following to Emeritus Membership, on recommendation of the Council and Component Society involved:

Anne Arundel County Medical Society:

Robert R Hahn MD, Severna Park

Baltimore City Medical Society:

William C Dunnigan MD, Baltimore

F A Pacienza MD, Baltimore

Harry N Rudin MD, Baltimore

William Schuman MD, Baltimore

Carroll County Medical Society:

Robert S McVaugh MD, Taneytown

Howard County Medical Society:

Theodore R Shrop MD, Ellicott City

Montgomery County Medical Society:

Henry W Jaeger MD, Silver Spring

Talbot County Medical Society:

Shepard Krech Jr MD, Easton

Washington County Medical Society:

M C Smoot MD, Hagerstown

Affiliate:

Lester W Harris MD, Ocean City

5. On recommendation of Council, adopted the following:

Resolved, That the membership of this society be informed that the Medical and Chirurgical Faculty has taken no official stand to date on PSRO as embodied in HR1 (the Bennett amendment); and

Resolved, That in the ensuing months every effort of our society and its members be expended to acquaint themselves with the law and its (as yet unpublished) regulations so that an informed decision may be made at the appropriate time.

6. Adopted unanimously two memorial resolutions honoring the following deceased physicians:

Archie R Cohen MD, Clear Spring

J Sheldon Eastland MD, Baltimore

7. Received for information the 1973 budget from the Treasurer, it having been adopted by the Council; and heard that the books for 1972 have been audited and that the printed report will be available at the 1973 Semiannual Session.
8. Adopted various Bylaw amendments, including one that would permit residents and interns to be full active members of the Faculty on payment of full, active dues.
9. Received the Nominating Committee report.
10. Heard an address by Russell B Roth MD, President-elect of the AMA.

The House met again on Friday, April 27, 1973 at the Faculty building and took the following actions:

1. By unanimous consent, dispensed with a ballot and elected the slate of the Nominating Committee to office.
2. Heard verbal reports from the Continuing Medical Education Committee, the Maryland Medical Political Action Committee, the Maryland Foundation for Health Care, and the President of the Woman's Auxiliary. Full reports will be published with the transactions of the meeting in the August issue of the *Maryland State Medical Journal*.
3. Adopted the following substitute resolved for Resolution 1A/73:

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland do everything in its power to effect changes in Maryland's Medicaid program to accomplish the objective that Usual, Customary and Reasonable fees be paid under the State's Medicaid program.

4. Tabled Resolution 2A/73; rejected both a substitute Resolved for Resolution 3A/73 and the Resolution itself; rejected Resolution 4A/73; and rejected both a substitute Resolved and the resolution itself on Resolution 5A/73.

Copies may be obtained from the Faculty office, or found in the August issue of the *Maryland State Medical Journal*.

5. Failed to obtain a two-thirds majority vote for consideration of Resolution 6A/73; introduced by the Prince George's County Medical Society.

Heard for information a resolution adopted by the Washington County Medical Society opposing the PSRO concept and any cooperation with it.

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Doctors in the News

A reception honoring **Dudley Phillips MD** for 25 years of service to the Darlington community and Harford County was held May 9 in the Darlington Fire Company Hall.

The reception was sponsored by the Darlington United Methodist Church, the local Lions Club, and the fire company.

A beloved figure in the community, Dr Phillips served as the first President of the Darlington Fire Company (1949-1968).

A 1945 grad from the University of Maryland School of Medicine, Dr Phillips opened his office in Darlington in 1947 after interning at Maryland General Hospital and serving as resident physician at Harford Memorial Hospital.

Just this year he was elected to the emeritus staff of Harford Memorial.

Aubrey D Richardson MD, Baltimore, has been named Faculty representative to the newly formed Baltimore Commission on the Aging and Retirement Education.

Peter H Wiernik MD, Chief of Medical Service, National Cancer Research Center, Baltimore, has been selected to serve as Chairman of the Patient Assistance Committee by the Baltimore City Unit of the American Cancer Society.

According to Dr Wiernik, "Our main objective for 1973 will be to insure that every needy cancer patient is referred to the American Cancer Society for counseling and aid where it is needed."

The following Maryland MDs have recently been certified as Fellows of the American College of Anesthesiologists:

Claro L LaVina, Cockeysville

Jose D Soriano, Salisbury
Alison Bradley Wilhelm, Cheverly

Also **Anis M Wassif MB**, Baltimore.

There were an estimated 345,000 physicians in the United States at the start of 1972, according to the American Medical Association. This represents a ratio of one doctor for every 612 Americans, compared with one for every 712 in 1960.

Moises Fraiman MD, Baltimore, has been reelected President of the Medical Staff and Executive Committee for Baltimore's Lutheran Hospital.


Donald Stuart Gann MD, Professor of Biomedical Engineering and Associate Professor of Surgery, Johns Hopkins Hospital, has been appointed Director of Emergency Medical Services.

Prior to his appointments at the Hopkins, Dr Gann was Professor and Director of Biomedical Engineering, Professor of Physiology, and Assistant Professor of Surgery at Case Western Reserve University.

He received his bachelor's degree from Dartmouth and his MD from the Hopkins.

Two Montgomery County physicians, **Howard Levine** and **Henry Roth**, have recently completed their boards in the subspecialty of Rheumatology and are certified as Diplomates in Rheumatology.

Another Montgomery County physician, **Aaron H Traum**, has been named by the State Department of Health and Mental Hygiene to the new advisory board of Mount Wilson State Hospital.

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FRANKLIN SQUARE HOSPITAL

Franklin Square Hospital, observing its 75th Anniversary this month, opened its doors for the first time on July 26, 1898 as the new 20-bed National Temperance Hospital and Maryland Medical College. At the time it was the only hospital in West Baltimore.

The hospital moved from Baltimore Street in 1901, because larger quarters were needed. Two adjoining houses were purchased on the corner of Calhoun and Fayette streets. One of these was the Civil War home of Governor Braddock. At this time the hospital took its name from the pleasant park across the street, known as Franklin Square.

With changing times, thousands of families moved away; homes along the route of the East-West Expressway were razed. By 1965 the hospital found that it could not remain open. Although the quality of its medical care had remained excellent, the community could not support it. Accredited in 1914 (the first year that any hospital was accredited), the hospital has always been well regarded in the medical world.

The crisis was solved in that same year of 1965 by the serendipitous confluence of a group of concerned residents of eastern Baltimore County, whose objective was to build a hospital in that area, with a Board of Trustees seeking means for the dispersal of the various elements of an existing hospital. The two interests merged. A "Citizens for Franklin Square Hospital Committee" was formed and a building fund campaign ensued.

Nearly two million dollars was raised. With a State loan and some other funds, the hospital was completed for 7.5 million dollars, probably the lowest cost-per-bed figure in modern times for a complete 300-bed general hospital. Yet, no shortcuts were permitted. Everything needed for patient comfort was included.

A major cost-cutting innovation is the complete absence of a kitchen. Franklin Square Hospital was the first hospital on the Eastern Seaboard to combine convenience foods with disposables. As there is no kitchen, there are no ovens, ranges, steamtables, dishwashers, or sterilizers, and less space is required. Patients enjoy a 14-day menu cycle, foods prepared under nearly laboratory conditions, and can dine when they choose because the system is flexible.

The new hospital opened its doors in its new location on Dec 9, 1969. Since that time, well



1901-1969—This was the West Baltimore home of Franklin Square Hospital for nearly 70 years.

over 250,000 people have visited the Emergency Room and Outpatient Clinic and over 300,000 patient days have been recorded for inpatients.

The rate of 80,000 outpatient visits per year was not anticipated. Within 17 months of the opening date, over 100,000 outpatients had used the facility. In 1972 it was necessary to construct several temporary buildings nearby to accommodate all follow-up outpatient visits and to enlarge the laboratory space. In the fall of 1971, the hospital's Board of Trustees established a ten-year Development Plan which includes new construction for additional beds, a Medical Arts Building, and other buildings for diagnostic and outpatient care. Development funding plans were announced in November 1972; the funding will be an on-going project.

The hospital shares a 215-acre campus with Essex Community College. The hospital's School of Nursing, started in 1901, was phased into the college in 1968. Since the opening date of the hospital, a number of other para-medical courses have been established at the college that work in conjunction with the hospital. Among these are a 30-month Radiology Technologist course which leads to an Associate of Arts degree, a Physician's Assistant Program, Laboratory Technologist courses, and others. More such courses are in the planning stage.

Franklin Square Hospital is one of two hospitals in Maryland to offer a residency in Family

Practice, a step toward the teaching of General Practitioners deemed necessary in the face of rising hospital costs as a prerequisite step in reducing the case load of the Outpatient Department.

The President of the Board of Trustees is Carville M Akehurst, the Medical Director is D Thomas Crawford MD, and the Executive Director is Sanford Kotzen.

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FOR CRISIS' SAKE, WHAT'S NEXT!

Russel B Roth MD, President-elect of the AMA, was the featured speaker at the MMPAC Luncheon held during the recent Annual Meeting. Dr Roth is a graduate of Yale and of Johns Hopkins University School of Medicine. He practices urology.

Dr Roth said it was apparent to him that practicing physicians in this country feel they have become a beleaguered profession in this land of the free and home of the brave. Despite the fact that modern medicine is actually able to do more for patients with each passing year, it finds more and greater restrictions placed on its ability to do those things. Possibly the public has been oversold on the miracles of modern medicine resulting in considerable overexpectation. Dr Roth also said that, unquestionably, doctors have occasionally abused their freedom.

The physician in 1973 must learn to adjust to and cope with numerous facets of modern life. Despite a greater knowledge of nutrition, fad diet books are outstandingly successful. Astrology is growing rapidly in popularity, and acupuncture has been legalized in Nevada. Chiropractors have even been included in Medicare. Public attitudes have caused these develop-

ments and many others, and the physician must reconcile himself to these public attitudes. In view of all this, increasing government activity in the health field is hardly surprising.

The Secretary of HEW's Commission on Medical Malpractice recently released its report. Among the less-publicized findings were these: litigants have less than a 50% chance of collecting anything and less than a 50% chance of collecting more than \$2000.

Dr Roth said that, rightly or wrongly, frustrated physicians often feel that the track record of their county and state medical societies has not been good in helping their members cope with recent developments affecting medicine. Organized medicine has long endured attack from the left. Attack from the right is a new development epitomized by union-forming doctors and organizations such as the Council of Medical Staffs.

Unfortunately, the AMA cannot point with pride, yet at least, to accomplishments in the control of malpractice suits or in freeing doctors from Phase 3 restrictions. However, there are other areas in which the AMA has accomplished much. With regard to the PSRO law — there were

five objectionable areas of the Bennett amendment, four of which were removed through negotiation before the law was passed. Some states have pledged full cooperation with the law while others indicate they will not accede to its provisions. It will be very interesting to follow developments, and see how it all works out.

The AMA also has reason to be pleased with its record regarding the HMO drive. HMOs were originally a Republican gimmick introduced for political advantage. The idea was subsequently picked up by Senator Kennedy and the Democrats with predictable results. However, the Kennedy bill has been whittled down from \$5 billion last year to \$1.5 billion this year. The Administration is currently in favor of a \$60 million limit to continue experimentation with the HMO concept. This figure has also been reduced from last year.

In the field of National Health Insurance legislation, the AMA now has approximately 185 sponsors for its Mediredit proposal. This is many times more than any other proposal has. While it doesn't mean Mediredit will necessarily be passed, it does mean that the AMA has influence in that many congressional offices. AMA has grown

greatly in influence within the last ten years, and all freshmen legislators are familiar with AMPAC.

Dr Roth emphasized that the health care crisis is one of finances — not of quality — and the physicians' component of the cost of medical care is a negligible 13¢ on the dollar.

He concluded by saying that the PAC movement is one of the best remedies for physician frustration and urged his audience to join PAC and become active in its affairs.

Congresswoman Marjorie Holt was also a guest at the luncheon. She again expressed her gratitude for MMPAC's early support which she feels was vitally important to her campaign.

Mrs Holt said she has enjoyed her first three months in office. She feels that progress is being made in forcing the Congress to hold the line against spending. She also indicated that she can see the influence of groups such as PAC in the Congress.



PRINCIPAL SPEAKER at the MMPAC Luncheon at the 175th Annual Meeting was Russell B Roth MD, AMA President-elect. Congresswoman Marjorie Holt (Republican, 4th Dist) also addressed the 125 attendees.



AMA-ERF GRANTS—One of the privileges enjoyed by the Faculty President is the annual presentation of AMA-ERF checks to the deans of the two Maryland medical schools during the Annual Meeting. Here we see DeWitt E DeLawter MD, presiding at the Presidential Banquet, and sharing \$22,183.83 with Russell Morgan MD, Dean, Johns Hopkins School of Medicine (center), and John H Moxley III MD, Dean, University of Maryland School of Medicine. These funds were a portion of the \$963,823 in grants US medical schools are receiving from the American Medical Education-Education and Research Foundation. The AMA-ERF is funded by donations from doctors and their wives through the AMA Woman's Auxiliary. Since the program began in 1951, a total of \$23,843,234 has been distributed to medical schools. In addition, the AMA-ERF has guaranteed more than 48,000 loans, totaling more than \$50 million, to medical students, interns, and residents. A special, interest-free loan program is available to especially needy individuals.

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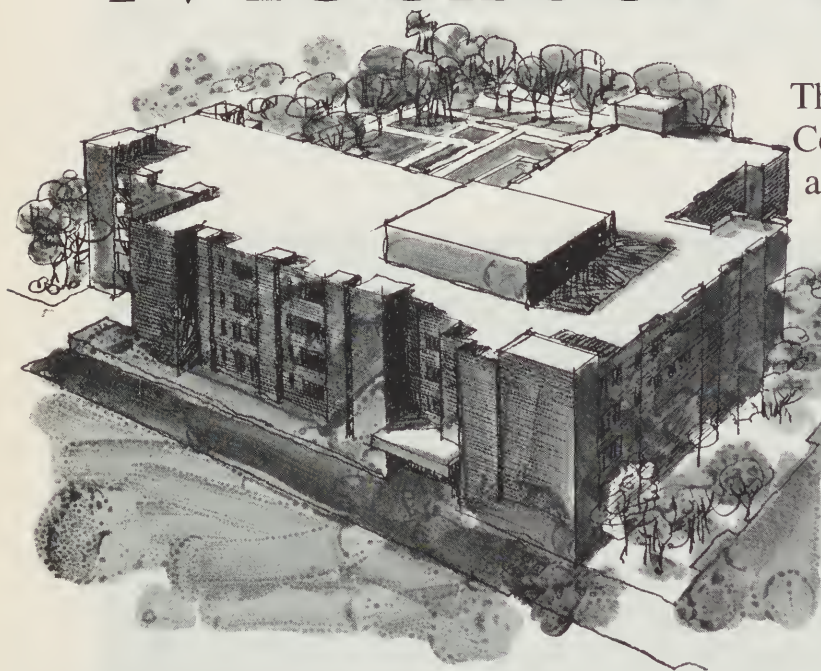
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J Sheldon Eastland MD

Dr J Sheldon Eastland, 1958-1959 President of the Medical and Chirurgical Faculty of Maryland, died April 20 at Mercy Hospital in Baltimore at age 74 after a long illness.

Born in Bennington NY, he was the son of a pharmacist. He graduated from the Johns Hopkins University in 1921 and received his MD from the University of Maryland School of Medicine in 1925.

He interned and took his residency at Mercy Hospital, where he spent more than 40 years on the medical staff, eventually becoming President. Just last year he was honored at a testimonial dinner given by Mercy's medical staff to celebrate his more than 40 years of service to that institution.

Dr Eastland served in many public and medical capacities. He had been on Maryland Industrial Accident Commission's medical board for occupational diseases.

In addition to serving as Faculty President in 1958 and 1959, and as a Maryland delegate to the AMA House of Delegates, he also served as Chairman of the Faculty's Committee on Diabetes.

Dr Eastland was Chairman of the Board of Trustees of the Maryland Blue Shield from 1968 to 1972.

He had been Associate Professor of Medicine at the University of Maryland School of Medicine and was affiliated with these hospitals: Greater Baltimore Medical Center, St Joseph, and Union Memorial, in addition to Mercy.

He was a member of the Baltimore City Medical Society, the American College of Physicians, the American Society of Internal Medicine, and the American Diabetes Association.

He was also a member of the Sons of the Revolution, the St George's Society, and the Society of the War of 1812.

Dr Eastland retired from private practice last year, but continued to remain active as a consultant at several hospitals.



Dr Eastland

He is survived by his wife, the former Emma Humphreys, of Baltimore.

At a meeting of the House of Delegates on April 25, a special resolution was unanimously adopted honoring Dr Eastland.

Typical of the words of praise in remembrance of Dr Eastland were those of a fellow physician, John R Davis MD, in a local paper:

"He was my teacher and friend . . . a wonderful doctor. He was highly thought of by his patients. They loved him and had much empathy for them. . . . He did a great deal for humanity."

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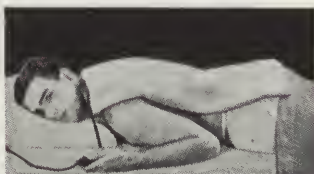
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executive director's newsletter

July 1973

ASSUMES PRESIDENCY

On Friday, May 18, your Executive Director became the President of the Maryland Society of Association Executives for a one-year term.

COMPONENT VISITS

A concerted effort is being made to have officers of the Faculty visit all components during the coming year. Visits have already been made by the President to Charles, Kent, and Anne Arundel Counties.

Advance notice is the key to having a Faculty officer on hand for your next component society session. Let us or the President know when and where your meeting is to be held. Every attempt will be made to fit this into the schedule of either the President or President-elect.

ANNUAL REPORTS

The Annual Reports will be published in the August issue of the Maryland State Medical Journal. Be on the lookout for this issue and be sure to read it. You will be amazed at the amount of work that is conducted quietly and without fuss or fanfare by countless Faculty committees.

Delegates are reminded to bring these annual reports with them to the Semiannual Session, Saturday, Sept 15, 1973, at the Faculty Building. Copies are not available for redistribution.

RESOLUTIONS DEADLINE

The deadline for receipt of resolutions for consideration at the Semiannual Session on Saturday, Sept 15, 1973 is

MONDAY, JULY 23, 1973

in the Faculty office. The normal deadline date would be Saturday, July 21. However, because of mail schedules, the deadline is as shown, Monday, July 23, 1973.

SMALLPOX IMMUNIZATIONS

The Faculty supports recommendations of the AHA and the National Center for Disease Control that all hospitals establish a program of vaccination against smallpox of all employees and staff.

Other physicians and their employees, not associated with hospitals, should voluntarily seek such revaccination to assure they are adequately protected.

Individuals in groups of "high risk" exposure to smallpox should also maintain their immunity to such disease.

MMPAC
ELECTION

New officers of the Maryland Medical Political Action Committee are:

Chairman

Francis C Mayle, MD, Bethesda (1973-75)

Vice Chairman

Robert J Thomas, MD, Frederick (1973-75)

Treasurer

Joseph J Harrison, Comptroller, Medical and
Chirurgical Faculty (1973-75)

Asst Treasurer

Neil Novin, MD, Baltimore (1973-75)

Secretary

Mrs Francis (Barbara) Mayle, Washington DC
(1973-75)

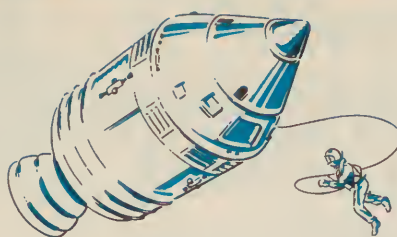
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John Sargent
Executive Director



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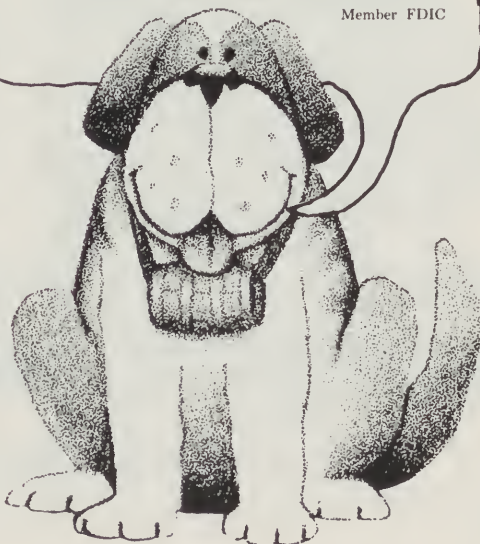
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PRESIDENTS ALL—AMA President-elect Russell B Roth MD posed for a group picture with Med-Chi Past Presidents at the Wednesday evening Past Presidents' Dinner (April 25) during the 175th Annual Meeting. This was another Annual Meeting "first." Seated L/R: W McKendree Boyer MD, 1963; John F Schaefer MD, 1971; Dr Roth; DeWitt E DeLawter MD, 1972; Whitmer B Frior MD, 1960. Standing L/R: Richard D Bauer MD, 1967; Charles F O'Donnell MD, 1962; A Austin Pearre MD, 1950; Howard F Kinnamon MD, 1961; Bender B Kneisley MD, 1954. Not present for this picture were Harvey B Stone MD, 1941; W Houston Toulson MD, 1949; George H Yeager MD, 1955; William H F Warthen MD, 1956; Leslie E Daugherty MD, 1959; Robert vL Campbell MD, 1965; J Morris Reese MD, 1966; Arthur G Siwinski MD, 1968; Russell S Fisher MD, 1963; Henry A Briele MD, 1970.

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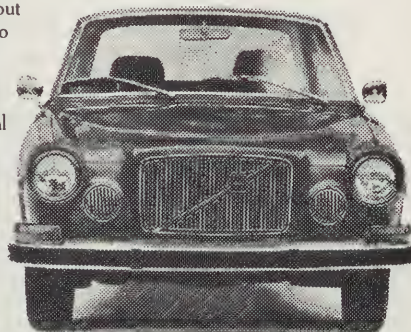
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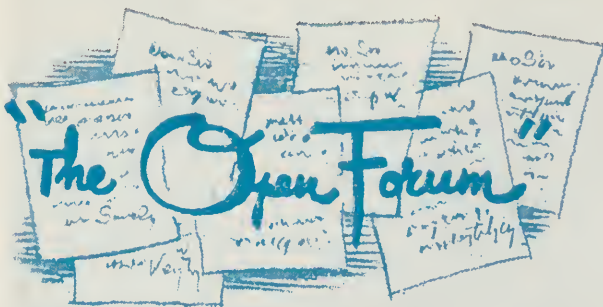


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Med-Chi members are invited to write to the editor expressing their opinions or giving information on matters of mutual interest. The Editorial Board reserves the right to select or reject communications. As with other material, all correspondence will be subject to the usual editing and possible abridgement. Material should be typewritten, double spaced, of reasonable length, and not over two pages. Address: The Editor, MARYLAND STATE MEDICAL JOURNAL, 1211 Cathedral St, Baltimore, Md 21201.

I am editing a book on renown and notable physicians and their faith.

I am interested in obtaining contributors who have a special knowledge of the faith and/or religion of one or more notable and outstanding physicians. I am considering such physicians as Sir William Osler, and Sir William Fleming; however the notable physicians could still be alive.

Anyone interested in this project or who would suggest renown physicians to write about may contact me at the following address (Thanks in advance.):

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PRESIDENTIAL PICTURES

TOP—AMA President-elect Russell B Roth MD, Erie Pa, is flanked by 1972-1973 Faculty President DeWitt E DeLawter MD, Bethesda, left; and William Carl Ebeling III MD, Towson, 1973-1974 President, Medical and Chirurgical Faculty of Maryland.



CENTER—John F Schaefer MD, right, 1971-1972 Faculty President, receives the Past President's Plaque from Dr DeLawter at the Presidential Reception and Banquet at the Blue Crest North on Thursday evening, April 26.

LOWER—With the traditional passing of the gavel to Dr Ebeling, left, by Dr DeLawter, Dr Ebeling became the 1973-1974 Faculty President on April 27.



HAPPINESS IS . . . (175th Annual Meeting Versions)



(TOP) . . . being greeted at the registration desk by these four love-lies—a fair sampling of staff gals who assisted with registering the record attendance. L/R they are Terry Bromwell, Jo Ann Ptak, Novella Wallace, Diane Winder.

(CENTER) . . . sampling the Wednesday hospitality night goodies at the Holiday Inn—Downtown.



(LOWER) . . . helping with the drawing of the two trips to Mexico City during the Semiannual Meeting in September. Dr DeLawter obviously enjoyed his part as did Denise Germuth. The lucky winners were Dr and Mrs Henry V Davis of Chesapeake City. Mrs Elmer G Linhardt, AMA-ERF State Chairman, is also happy to report that \$1,822 was raised for the two Baltimore medical schools through efforts of the Woman's Auxiliary for this MEXICAN HOLIDAY.



175th Annual Meeting Sets Many Records

CROWDS AND RECORDS were the order of the day at the Baltimore Civic Center April 25-27, 1973 at the 175th Annual Meeting of the Faculty. Registration reached an all-time high with over 2,100 registered; physician members accounted for 1,200 and students and other health personnel the remainder. TOP—Record attendance occurred at scientific sessions, as attested by this photo. CENTER—Lunch-and-learn session on Thursday also established a record, both for attendance and interest. LOWER—All available exhibit space was taken; exhibits were many and varied; only a small section is pictured here.



50 Clinical Pharmacology Training Programs Described

The first detailed guide to training programs in clinical pharmacology—the study of drugs in man—has just been published by Pfizer Inc.

The 105-page booklet, entitled "Clinical Pharmacology—A Guide to Training Programs," describes the 50 programs offered throughout the United States and Canada. Included are the clinical focus of each program, the facilities and training support available to the student, a listing of the faculty, a description of the school, and application procedures.

Noting in the preface that the demand for specialists in clinical pharmacology exceeds the supply, Dr Sheldon Gilgore, President of Pfizer Pharmaceuticals, states that the booklet is a guide for "young physicians who are looking for the challenge that clinical pharmacology will increasingly offer, both as a scientific discipline and as a very direct means of service to society."

Dr Louis Lasagna, Director of the Department of Pharmacology and Toxicology, University of Rochester School of Medicine, writes in the introduction that well-trained clinical pharmacologists are "desperately needed" to help discover and evaluate new drugs, and that this booklet will provide "invaluable help for those who contemplate careers in this exciting discipline."

The American Society for Pharmacology and Experimental Therapeutics points out in introductory remarks that it "is pleased to see a new compendium of active programs in clinical pharmacology" and that "the Society stands ready to encourage and help prospective clinical pharmacologists as they explore what is perhaps the most exciting area of basic science that directly relates and applies to man."

Descriptions of the various programs are written by the directors. Items covered in the booklet include names of recent graduates and their career choices as well as a selection of staff publications. It also contains a separate section on sources of support for trainees in clinical pharmacology.

Copies of the booklet will be made available to medical schools for distribution to physicians interested in pursuing a career in clinical pharmacology. A limited number of copies also are available to physicians from the Pfizer Public Affairs Division, 235 E 42nd St, New York NY 10017.

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woman's auxiliary



WOMAN'S AUXILIARY LUNCHEON head table personages at the 175th Annual Meeting included L/R: John Sargeant, Executive Director; Paul Mullan MD, Public Relations Chairman; William Carl Ebeling III MD, Faculty President-elect; Mrs Leslie R Miles, 1973 President; Ra'bbi Henry Segal, who gave the invocation; Mrs Marvin L Kolkin, who presided as 1972 President; Russell R Roth MD, AMA President-elect, who addressed the luncheon gathering on "Pills, Patients & Politics"; Mrs Norman Gardner, Eastern Region Vice President; DeWitt E DeLawter MD, 1972 Faculty President; Dr Kolkin; Mrs Roger E Windsor, Convention Committee Co-chairman; Dr Miles; Mrs DeWitt E DeLawter, Convention Committee Co-chairman.

INAUGURAL ADDRESS-1973

A wise man once said, "Speak softly for then only those nearby will realize how little you know." This seems without a doubt to be timely advice for me at the moment. However, there is an inaugural address listed in our program, and Caryl has done such a monumental job in preparing me for the coming year, as have so many others, that it would really be a put-down to speak too softly today. I am happy to have the opportunity to publicly thank all the people who have helped me prepare for the coming year. I am sure that with your help and support their efforts will not have been in vain.

Our Auxiliary has made much progress this year, as it has in each year of its existence. Its growth depends entirely on each of you, and I sincerely hope that you will all continue your efforts toward the further growth and progress of this fine organization.

There are times when I feel that each county or state feels itself a separate entity; each working in its own way; each with its own problems. I

wish that every one of you could have the opportunity just once of going to a national convention, listening to the state reports, and talking to the many women who devote their time to our Auxiliary. You would soon realize that no matter how large or small your Auxiliary is, the job it does is an important one in the overall national picture. The total of AMA-ERF contributions for one year is an excellent example.

You would also realize that although our state is doing well, it could be doing better, particularly in the area of membership. It is somewhat disheartening to hear the percentages of Auxiliary membership as compared to the number of physicians in each state. We are definitely not on the top of the pile! Won't each of you carry on your own local membership drive? We all have friends who are physician's wives, and we all know that people have interests other than the Auxiliary. On this subject, let me say that this can be an advantage rather than a deterrent to joining a medical auxiliary. Most im-

portantly, we all have husbands who are physicians. That is our common bond, and that is what makes us an Auxiliary. Obviously then, our first obligation is to our husbands—to their medical societies. As you plan your programs for the year, consult these men as to their wishes and needs and their feelings as to the needs of your local communities. We can truly be an Auxiliary if we work closely with our medical societies. I am sure some of you are thinking that the men don't even know we exist—as a group, that is—and you just might be thinking that some of them wish we didn't. But who's fault is that? What kind of picture does your Auxiliary portray to the men? Stop and think about it. You are the only ones who can change that picture, if it does not suit you.

I challenge anyone here to find another organization with a program more diversified than the Auxiliary program. The possibilities are unlimited as to where you may want to channel your efforts. It would be a dull world if we were all interested in the same things, but it would seem to me that almost anyone would be interested in some phase of the Auxiliary program.

When we speak of community service and health education, you as physicians' wives are in the most logical position to recognize the local needs and work on a solution to the problems. Your Auxiliary should in many cases be a catalyst. Finding someone to do a job once the need is established is every bit as important as doing it yourselves. This is where membership in other organizations will only serve to promote cooperation.

Health Manpower and AMA-ERF should both be areas of concern to a doctor's wife, and who better to give the local communities a clear picture of the great need for manpower in the health field and money for research and the education of our young physicians. Our husbands do not, as a rule, have time to promote these things to any great extent, and we cannot expect the general public to support them if we do not educate them to the needs.

Are we all in a position to discuss current medical legislation intelligently? Do we know and understand the function of MMPAC? Maybe there are those of us who would like to learn more about this aspect of Auxiliary work.

Many of our members spend long hours of service on projects concerned with international health. Our efforts are well recognized and deeply appreciated in many faraway places. If you are interested in this type of work, or in giving some friendly help to our foreign doctors' wives,

you have just hit upon still another phase of our Auxiliary program.

Last, but certainly not least, is the social aspect of the Auxiliary. Everybody loves a party, and there are so many reasons for having parties—both for fun and profit as they say. The greatest reason of all though is to promote fellowship within your own group.

In the little book, "Happiness is a Warm Puppy," Lucy said, "Happiness is one thing to one person, another thing to another person." I sincerely hope you will each find your bit of happiness in our Auxiliary. I urge every county to become very active participants at the state level. We need each of you. Your opinions and suggestions are invaluable in planning the over-all state program. Use the many resources we have available to you, and please call on us at any time you feel we can be of help to you. Remember, the counties are the heart of this organization, and the reason we exist as a state board is to be of service to you.

I wish each of you a most successful and rewarding Auxiliary year.

Thank you!

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Scientific sessions (plus meetings of the Woman's Auxiliary) will be held at the Instituto Nacional de Cardiologia and will include subjects of interest to physicians in all specialities such as

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Among the speakers will be Doctors **Ignacio Chevez, Isaac Costero, Demetrio Sodi-Pallares, Raul Baz, and Jorge Espino Vela.**

Scientific sessions will be scheduled early in the day to allow free time for shopping and sightseeing.

THIS SCIENTIFIC PROGRAM WILL BE ACCEPTABLE FOR TEN CREDIT HOURS BY THE AMA PHYSICIAN'S RECOGNITION AWARD AND CONTINUING MEDICAL EDUCATION REQUIREMENTS OF THE MARYLAND STATE BOARD OF MEDICAL EXAMINERS.

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I would like to make a reservation for the MED-CHI SEMIANNUAL MEETING IN MEXICO CITY, SEPT 19-23, 1973. Enclosed is a deposit of \$..... (\$50 per person, made payable to TRAVEL GUIDE AGENCY LTD) for #..... reservations. The balance will be payable no later than Aug 1, 1973. All deposits and monies are refundable in full until August 1, after which refunds are subject to resale of the reservation(s).

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ACTIVITIES SCHEDULE—SEMIANNUAL MEETING

SEPT 15

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SEPT 19

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SEPT 19-23

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Gala Farewell Party . . . cocktails, dinner, dancing, and lavish entertainment in the beautiful ballroom . . . a grand finale to the 1973 Semiannual Meeting.

SEPT 23

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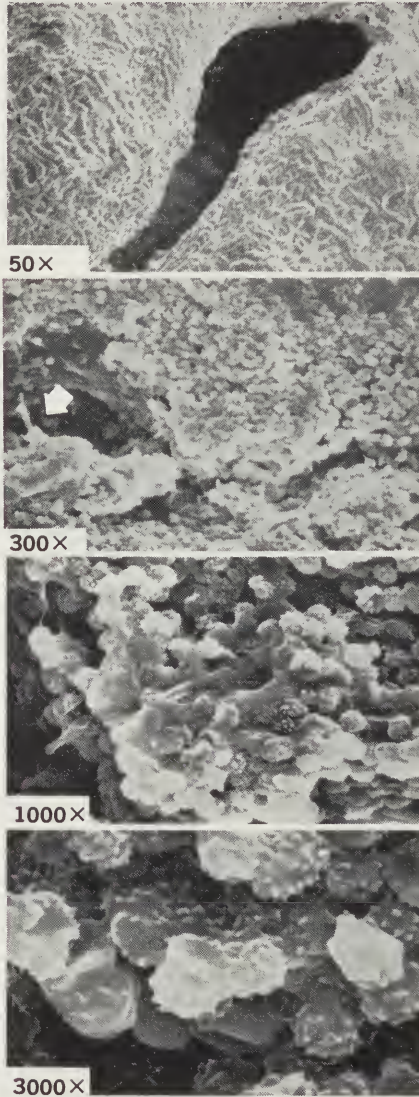
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Progress in

Diagnosis

In these illustrations of tissue from a patient with acute cystitis, you can see the swollen and inflamed mucosa of the ureteral orifice (50X), a fibrin strand (300X), and a whitish exudate composed of polymorphonuclear leukocytes (1000X and 3000X). The photographs were taken with the scanning electron microscope (SEM) by Dr. Shirley Siew, Associate Professor of Pathology at the University of Pittsburgh School of Medicine. They come from the clinical exhibit "Scanning Electron Microscopy of Urinary Tract Infection," which won first prize in Clinical Research at the May 1972 meeting of the American Urological Association.

The scanning electron microscope promises to be extremely useful in its investigation of human pathology. In time, examination of tissue with the SEM is likely to play a significant role in the diagnosis of urinary tract infection.



A note on the photography:

These photographs were made by the scanning electron microscope, which, like the transmission electron microscope, operates on the basic principle of exposure of tissue to a beam of electrons in a vacuum. With the SEM, electrons bombard the surface of tissue which has been given a fine coating of gold. The electrons reflect off the tissue onto a television screen, and the resulting photograph shows a three-dimensional effect. The tissue sections need to be ultrathin, so there is a minimum of handling and distortion.

Just as much an instrument of progress and just as helpful in its way has been Gantrisin (sulfisoxazole) Roche, developed and introduced a generation ago. However, there's been no generation gap in its continuing usefulness. In fact, Gantrisin, with so many years of clinical experience behind it, is still one of the most valuable drugs we have for the treatment of non-obstructed cystitis, pyelitis or pyelonephritis due to susceptible organisms such as *E. coli*. Specifically, Gantrisin provides your patient with certain important therapeutic advantages:

References: 1. Bran, J. L.; Karl, D. M., and Kaye, D.: *Clin. Pharmacol. Ther.*, 12:525, 1971. 2. Burke, E. C., and Stickler, G. B.: *Mayo Clin. Proc.*, 44:318, 1969. 3. Hibbard, L. T., in Bulger, M. J., et al.: *Patient Care*, 1:(3) 47, 1967. 4. Holloway, W. J.; Furlong, J. H., and Scott, E. G.: *J. Urol.*, 102:249, 1969. 5. House, T. E., et al.: *Obstet. Gynecol.*, 34:670, 1969. 6. Lampe, W. T.: *J. Am. Geriatr. Soc.*, 16:798, 1968. 7. Moffat, N. A., and Wenzel, F. J.: *Curr. Ther. Res.*, 13:286, 1971. 8. Normand, I. C. S.: *Practitioner*, 204:91, 1970. 9. Pryles, C. V.: *Med. Clin. North Am.*, 54:1077, 1970. 10. Seneca, H.; Peer, P., and Warren, B.: *J. Urol.*, 99:337, 1968. 11. Trafton, H. M., and Lind, H. E.: *J. Urol.*, 101:392, 1969. 12. Cohen, M.: *Pediatrics*, 50:271, 1972.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms.

IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml;

measure levels as variations may cause. **Contraindications:** Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term during the nursing period.

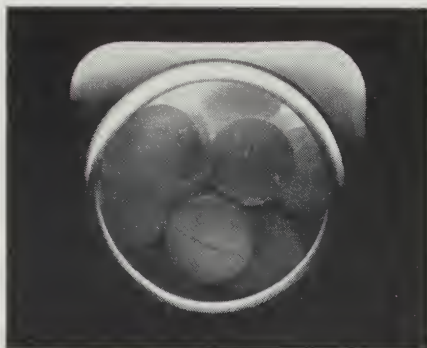
Warnings: Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as such (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, purpura or jaundice may be early indications of serious blood disorders. Blood and urinalysis with careful microscopic

Acute cystitis:

Treatment

High urinary levels As a urinary antimicrobial, Gantrisin (sulfisoxazole) offers your patients important advantages. Therapeutic urinary and plasma concentrations are usually reached in from 2 to 3 hours and can be maintained on the recommended 8 Gm/day dosage schedule that's convenient for almost all patients.

Generally good tolerance Gantrisin causes relatively few undesirable reactions, and serious toxic reactions are rare. Minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. Hence, Gantrisin may usually be given even for extended periods in treating chronic or recurrent nonobstructed cystitis, pyelitis or pyelonephritis due to *E. coli* and other susceptible organisms. (See Important Note in summary of product



information.) Complete blood counts and urinalyses, with careful microscopic examination, should be performed frequently.

High solubility Gantrisin (sulfisoxazole) Roche is one of the most soluble of all sulfonamides, with both free and acetylated forms highly soluble in the commonly encountered urinary pH range of 5.5 to 6.5. Urine levels have been detected in

60 minutes; therapeutic levels are usually reached in from 2 to 3 hours. About 90% of a single dose is excreted in 24 to 48 hours. As with all sulfonamides, adequate fluid intake must be maintained.

economy Average cost of therapy is still only about 6½¢ per tablet.

total therapy: 14 days Recent evidence in the medical literature suggests that therapy in acute non-obstructed urinary tract infections should be continued for 10 to 14 days even if patients become asymptomatic in 2 or 3 days, as they often do.¹⁻¹¹ However, one investigator, evaluating a 5-year study of sulfisoxazole used to treat urinary tract infection in 368 girls, found no advantage in continuing therapy more than two weeks for a first infection.¹²

For acute, chronic or recurrent nonobstructed cystitis, pyelitis, or pyelonephritis due to susceptible organisms...

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Mental Anguish as an Element of Damages in Malpractice Cases

JAMES G ZIMMERLY MD JD MPH

WALTER A OLENIEWSKI JD MS

From the Armed Forces Institute of Pathology (AFIP), Washington DC 20306.

Dr Zimmerly is Chief, Legal Medicine Section, Forensic Pathology Branch, AFIP; also Associate Professorial Lecturer in Forensic Medicine, George Washington University.

Dr Oleniewski is Attorney US Army Claims Service, Fort George G Meade Md.

Information and reprint requests to Dr Zimmerly.

In recent medical malpractice actions, claims for damages for alleged mental anguish have become more prominent. The reasons for such a trend are not readily apparent; some possible explanations are suggested, however. In certain types of malpractice claims it is possible to have mental anguish without any physical damage. For instance, an unauthorized surgical procedure may cause mental distress to a patient and at the same time improve the patient's physical condition.

While this type of case has not been the reason for the increase in claims wherein mental anguish has been alleged, it provides an illustration of the problem. An alternative explanation may be the fact that although claims alleging mental anguish are more difficult to prove, in those instances in which it can be proved the money awarded for mental anguish may be a great deal more than the money awarded for the physical injury.

Regardless of the reason for the trend, it must be conceded that mental anguish as an element of damages is undergoing a gradual transformation in our courts. In its earliest development, mental anguish was generally not recognized as an element of damages for which compensation could be allowed unless it was directly connected with a physical injury or was the direct and natural result of a wanton and intentional wrong.¹ Early decisions limited recovery for mental suffering to this narrow area because it was felt that such a claim could easily be fabricated. If some physical impact could be shown, however slight, there was a valid foundation for determining its genuineness and the extent to which it would have affected an injured party. This doctrine is slowly being eroded. In some jurisdictions the courts have gone to unusual extremes to find evidence of physical impact in order to allow a party the opportunity to recover

for mental suffering. A Georgia court in *Christy Bros Circus v Turnage* found sufficient physical impact in a case in which the defendant's horse "evacuated his bowels, into the plaintiff's lap."²

Mental anguish resulting from negligent medical treatment is normally an element of damages because pain or discomfort is easily found in most malpractice cases. When physical disability is shown, mental anguish has always been more readily accepted by the courts.

A brief sampling of decisions including damages for mental anguish in medical malpractice cases illustrates the breadth of the problem facing the medical profession. Courts have always permitted recovery for mental anguish for the negligent mishandling of corpses and for unauthorized autopsies. In such cases, the courts have indicated that mental suffering and injury to the feelings would be the ordinarily natural and proximate result of knowledge that the remains of a deceased loved one had been mutilated.³

In *Martin v Perth Amboy General Hospital*, the plaintiff was awarded \$36,000 for the physical and mental anguish resulting from a laparotomy pad's being left in his abdomen.⁴ A gauze pack left in a woman's vagina entitled her to recover damages for humiliation and embarrassment.⁵ In *Ferrara v Galluchio*, a woman whose shoulder was burned by X-ray treatments for bursitis developed cancerphobia and, in a suit against the radiologists, recovered damages that included \$15,000 for her mental anguish.⁶ The State of New York allowed a convict to recover for moral and mental degradation as a consequence of being incarcerated in a State mental institution for an inordinate length of time because of the inadequacy of hospital records and resulting lack of proper psychiatric care.⁷ A Connecticut court rendered the plaintiff an award for mental anguish when he came down with arachnoiditis resulting from contrast medium being left in his spinal canal after a myelogram.⁸

Humiliation caused by disfigurement is also compensable as a form of mental suffering.⁹ A 50-year-old woman was awarded \$115,000 by a California jury in 1949 in a suit against a plastic surgeon for disfiguring her breasts and abdomen in an attempt to improve their appearance. The California court held that the plaintiff could collect for mental anguish arising out of her disfigurement and humiliation, even

though the scars were covered by her clothing.¹⁰ A California hospital was liable for a female patient's mental anguish when she was intimately examined by ten or 12 medical students over her protestations.¹¹ After an unsuccessful sterilization operation, both parents were allowed to recover damages for their mental anguish when faced with an unwanted child.¹² This decision is clearly contrary to most sterilization failure cases that preceded it, but it is now precedent for such cases in California.

There is no universal rule, and each State has its own, but the trend is clearly moving away from the old rule that required a proof of physical impact before a recovery for mental anguish would be allowed. An increasing number of courts have regarded the physical consequences themselves or the circumstances of the incident as sufficient guarantee of mental disturbance, regardless of the presence or absence of physical impact. Maryland is an example of a State that does not require proof of physical impact to permit recovery for mental pain and suffering. It has long been established law in Maryland that recovery may be had for physical injuries resulting from nervous shock, even though there is no actual physical impact.¹³ This does not mean that recovery is being permitted where the defendant's negligence caused only mental anguish without resultant physical injury or physical consequences, at least not at the present time.

Because the temporary emotions of fright are so easily counterfeited, courts have been hesitant in granting awards in instances in which the plaintiff's only claim is for mental anguish. Examples of this type of case involve claims against hospitals for giving mothers the wrong baby to take home. In such a situation, after the mistake was discovered and rectified, the parents were not allowed to recover from the hospital for their mental distress.¹⁴ Nor were the parents allowed to recover if they were initially told the wrong sex of their baby.¹⁵ Such a suit may be successful if the plaintiff can prove that the defendant's actions were done with malice. In a 1969 case against a Michigan nursing home a plaintiff was held to have a cause of action for mental anguish arising out of the nursing home's failure to inform the plaintiff of his mother's pending death while she was a patient in the home.¹⁶ In the recent case of *Angulo v County of Riverside*, however, a mother who was given the wrong baby was awarded damages of \$10,000, even though the error was corrected and she was given her own child within five to seven hours. A California jury accepted her claim of

anxiety neurosis and resultant physical damage.¹⁷

The State of Maryland has a Wrongful Death Statute which allows damages for mental anguish in the case of the death of a spouse or a minor child.¹⁸ The damages for mental anguish and emotional pain and suffering are in addition to the damages of pecuniary loss, loss of society and consortium, companionship, comfort, protection, marital care, parental or filial care, advice, counsel, training, guidance, or education.¹⁹

The Maryland Wrongful Death Statute²⁰ is based on the English Lord Campbell Act which allowed an action to be brought for the benefit of the wife, husband, parent, and child of the person whose death was caused by the wrongful, negligent act or default of the defendant. The Maryland Statute creates a new and separate cause of action to compensate the survivors for the loss occasioned by the death. The statute requires that the action be brought for the benefit of persons related to the decedent by blood or marriage, the idea being to compensate those persons dependent on the decedent for support. The decedent's estate, not the beneficiaries, may bring a cause of action for expenses occasioned by the injury, pain and suffering of the decedent, and loss of earnings accruing between the time of the injury and the time of the death.²²

In order for a plaintiff to recover damages for mental anguish, the plaintiff must have been conscious at the time of the injury and/or subsequent thereto.²³ There can be no damages awarded for mental anguish in instances in which injury and death are instantaneous or in which the injured party never regains consciousness.

The plaintiff may testify as to his own mental suffering, and in certain instances the court may presume mental suffering from the nature of the claim, eg, unauthorized autopsies or injuries resulting in the loss of sight or hearing. Psychiatric testimony may be necessary in those cases in which the plaintiff alleges an injury caused neurosis or psychosis.

Mental anguish concerning possible future disability is also compensable.²⁴ The case of *Gentile v United States*²⁵ involved a claim of anxiety neurosis caused by a lost catheter in the patient's circulatory system. The alleged negligent act occurred at a Veterans hospital and resulted in a verdict of \$92,500.

As courts become more receptive to the arguments of persons claiming mental anguish the necessity of physical injury and physical impact will continue to be discarded in favor of a theory more concerned with the genuineness of the

claim, at least in the more liberal jurisdictions. With such a theory, the courts may grant claimants the same protections and remedies for mental injuries as are presently applied to physical injuries.

Once having found a violation by the defendant of a duty owed to the plaintiff, then, without looking for actual physical impact or attendant physical injuries, a court would concern itself with the effect on the plaintiff's state of mind and the causal relationship between the defendant's act or omission and the mental anguish suffered by the plaintiff. Medical malpractice actions are one type of tort in which claims alleging mental anguish are becoming more common. As the general tort law changes with regard to damages allowed for claims of mental anguish, we can expect to see these changes reflected in verdicts awarded in future malpractice cases.

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Leukemia Grants

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CONTRIBUTIONS OF MARYLAND PHYSICIANS TO MEDICAL JOURNALISM IN THE UNITED STATES

Medical Repository (1797 to 1824)
Philadelphia Medical Museum (1804)
American Medical Recorder (1818 to 1829)
Medical and Physical Recorder (1820-1827)
The American Journal of the Medical Sciences (1827-)

DOUGLAS CARROLL MD
Baltimore City Hospitals
Baltimore

This is the ninth of an 11-part series of articles on the history of medicine in Maryland from 1634 to 1835 as written by Dr Carroll.

After the close of the War of 1812, it seemed to Americans that no more obstacles stood in the way of the rapid progress of scientific thought, with all the material and spiritual advantages it would supposedly bring with it. The real political independence achieved by the war was accompanied by a desire to extend that independence to economics, to literature, and to science. American scholars intensified their natural history exploration in order to keep pace with the westward movement, developed a deep and abiding interest in research in the physical sciences, and began providing both an institutional basis for the pursuit of science and a domestic media for the dissemination of ideas and findings.

Advance was so rapid that an almost childlike faith in science became the rule among educated Americans. The assumption underlying scientific work was that pure Baconianism — collection, description, and classification — if pursued long enough and consistently enough, would inevitably lead not only to a rich and mature understanding of nature, but also to great material happiness. And it was naturally assumed that such understanding and happiness would also promote a lofty morality and an unshakable devotion to the Creator of all things. Benjamin Silliman's designation of his period as the "intellectual age of the world" is symptomatic.

George H Daniels, American Science in the Age of Jackson

The detailed case report is the basis of modern medical knowledge. Significant case reports with medical history, physical examination, clinical-pathological correlation, and statistical analysis started in Maryland in an organized manner in 1828 with Thomas Wright's *Reports from the Baltimore Alms-House Infirmary*. Over the next five years he contributed 14 articles incorporating clinical-pathological correlation. We have selected 1828 as the beginning of Period 3 in the history of medicine in Maryland, the beginning of scientific medicine. The following article summarizes the medical literature contributed by Maryland physicians to medical journals published outside of Maryland between 1797 and 1833. These publications are the best source on medical practice of this period, and are therefore reported in detail.

* * * * *

The first American medical journal was started by Samuel L Mitchill (1764-1831) in 1797. In 1808, there were ten medical journals

published in English, three were American.¹ Between 1797 and 1810, six medical journals were published in the United States (two in New York, two in Philadelphia, one in Baltimore, and one in Charleston) but only the *Medical Repository* lasted more than two years, coming to a close in 1824. In 1828, two Philadelphia journals combined to form the *American Journal of the Medical Sciences*, of which Osler said "one can almost write the progress of American medicine during the last century" from its pages.² By 1850, there were 117 medical journals published in the USA.

The *Medical Repository* was the only medical journal available to Maryland physicians in the eighteenth century. In it appeared the report of the Commissioners of Health to the Mayor on the yellow fever epidemic of 1797 (1:380, 1797), a report on the epidemic of 1800 by Dr Chatard (4:253, 1800) and by the Medical Faculty (4:351, 1800), articles by local doctors such as Grafton Duvall's report of a sickness in Frederick County

in 1804 (Hexade 2, vol 2:374, 1805), John Archer on cure of the Croup (2:27, 1799), John Archer Jr on diphtheria (2:82, 1799), John Mace's account of a malignant disease in Dorchester County in 1800 (5:345, 1802), and Nathaniel Potter on measles (6:353, 1803).

The *Philadelphia Medical Museum* appeared in 1805 under the editorship of John Redmon Coxe, then in his 83rd year. Only two volumes (1805 and 1806) appeared. Two preoccupations of the medical profession at that time are obvious. There are accounts of "cures" of epilepsy, reports of "singular," "extraordinary," "uncommon," and curious cases. The unusual, the miraculous titillated the interest of practitioners, possibly because they were so limited in what they could do to help patients. The reports of cures consist generally of one case, and there is no recognition that "cure" would probably have occurred without treatment. Coxe himself reports an albino. Watkins' reports on the "Efficiency of poke-berry juice in hemorrhoids." A report from the *Royal Humane Society of England* outlines the means of restoring suspended animation: "Introduce the pipe of a bellows into one nostril; the other, and the mouth being closed; inflate the lungs, till the breast be a little raised; the mouth and nostrils must then be let free: This process to be repeated till the return of life."

The other major preoccupation of medical writers is the epidemics. Mitchill reports on yellow fever in Virginia in 1741 and 1742; Drysdale reports on yellow fever in Baltimore in 1794 in a series of letters to the editor amounting to nearly 90 pages.

There are several articles from foreign authors, notes on the *American Philosophical Society*, and a good deal on pharmaceuticals. Generally, the articles are from American authors.

Vol 2 of *Philadelphia Medical Museum* for 1806 contains a number of case reports emphasizing treatment. Blood-letting in hemoptysis and in a wound of the lung are advocated.

Dr John B Davidge of Baltimore reports a dissection of the external genitalia of a patient whom he finally concluded was female, although there was some question during life.

There are two postmortem dissections reported, one by Monro Jr and Sr in Edinburgh on a case of diabetes and one by James Stuart on a yellow fever victim in Philadelphia. The liver was believed to be the only organ involved, apparently because of engorgement. It was concluded that the liver was inflamed, although the exact meaning of this term does not appear to be

clear.

Underlying this postmortem report, there is a rather naive assumption that because this examination was done, the professor should be able to conclude how the disease may be cured. Stuart concludes that cure depends on three indications: removal of the inflammatory diathesis, obviating the effect of this diathesis, and restoring the strength of the patient. The author appears to believe that he has made a contribution to the treatment of yellow fever.

Williamson gives "an account of the Diseases of Queen Anne's County, Eastern Shore of Maryland during 1802-03." He begins his account describing the swamps, ponds, and marshes common to the Eastern shore, noting that the atmosphere is known to be "much contaminated by the disengaged miasma; and that this atmosphere is one of the grand causes of autumnal diseases."

He then goes on to describe the common diseases seen in practice. He describes a child whose "family physician" had called in a "consulting physician" without avail. Williamson was finally called when the child seemed to be moribund. Treatment with cataplasms of bitter herbs and Peruvian bark to the lower abdomen and internally laudanum "to quiet his bowels" was followed by improvement and recovery.

Intermittent and bilious fever (probably malaria) was treated with a purgative of calomel and jalop, followed by Peruvian barks. Virginia snake root and salt of tartar seemed to make the bark more effective.

He notes that the local inhabitants are opposed to the use of calomel, but "they think the physician not master of his profession . . . if they are not indulged with" emetics.

A third disease, bilious fever, frequently of the intermittent type (probably malaria), "is always very manageable" when treated with calomel and jalop, followed by salt of tartar if a remission does not take place and then by bark as soon as the remission occurs.

A fourth disease is yellow fever, "what I conceived to be the highest grade of bilious fever." He describes one terminal case of what certainly today appears to have been yellow fever, which did not respond to a cathartic and a febrifuge. Williamson twice mentions that he rarely bleeds his patients.

He then describes a number of patients with dysentery, "typhus fever," chronic diarrhea, pleurisy and phthisical affections. Nearly all patients were treated with a purge, followed by a febrifuge mixture, then the bark.

Many of the fevers seem to have been malaria. The diarrheas and dysenteries could have been bacterial or amoebic. The only effective drug against the diseases he met was Peruvian bark for malaria. He had, however, a number of powerful drugs at his disposal: purges, emetics, mercury, and antimoney. Blisters and capping were not harmful and Williamson did not bleed his patients excessively.

Of George Williamson, little is known. He was probably born in Virginia. In his letter to the editor of the *Philadelphia Medical Museum* (2:170, 1805) he describes the diseases in Queen Anne's County in 1802-3 and says that he had not commenced practice at the beginning of this period. It seems possible that he started his practice on the Eastern Shore about 1803, moved later to Baltimore, where he was living in 1805. He was a member of the City Council in 1821, and died before 1837. In 1819 he edited Etienne Tourtelle's *The Principles of Health*, with introductions by Benjamin Rush, Nathaniel Potter, and Samuel L. Mitchell.

The *American Medical Recorder* (Vol 1, 1818, "Conducted by Several Respectable Physicians of Philadelphia") contained excellent abstracts of English, German, and French medical journals. These are workmanlike summaries of significant recent medical advances.

Robert Archer writes "On the Influence of Music on the Mouse." The editor, adroit in one-upmanship, draws attention to a similar case described in Barton's *Philadelphia Medical and Physical Journal*. There are a number of case reports with postmortem examinations, a case of sudden death, a case of congenital heart disease, and two on "habitual drunkards."

Contained herein is Nathaniel Potter's "A Memoir on Contagion" read before the Medical and Chirurgical Faculty June 3, 1817. Potter observes that he has cherished a hope that the problem of contagion of yellow fever had been solved once and for all—meaning that in his view it arose from local causes. But a British Army Medical Board has recently ruled that it is contagious and may be spread by commerce.

This was an extremely unpopular idea in the large seaports of the Eastern United States and Potter goes about proving that yellow fever is indigenous to certain areas and arises locally. Defining his terms carefully, Potter starts with Hippocrates and gives a historical review of the subject.

Particularly important to his argument is the fact that yellow fever existed in the early colonies of the United States — thus proving that it was local in origin.

He then describes his own experience. In 1797 an outbreak of yellow fever occurred in the Army garrison at Baltimore. Potter was called in and immediately concluded that the epidemic must originate from a miasmatic swamp. Such an area was discovered near the garrison, and Potter recommended that it be drained. It was drained, filled with earth, and not a man developed the severe form of the fever thereafter. This was proof to Potter that the epidemic had arisen locally in the pond and could not have been brought in by a ship.

He concluded that the three great epidemics in Baltimore in 1794, 1797, and 1800 were of domestic origin and noncontagious. All of these epidemics were confined to low ground. No cases occurred west of Jones Falls except on a September day a Southeast wind blew the miasma to Frederick, Gay, South, and Calvert streets where "all the horrors inseparable from so malignant a fever" occurred.

Vol 2 (1819) under new editorship (John Eberle MD), shows a general change in philosophy. Vol 1 contained several autopsy reports and experimental articles. Vol 2 has less case reports, more reviews. Epidemic cholera in Calcutta is reported. A successful thoracic paracentesis was carried out after the author had made the diagnosis of pleural fluid by hearing a succussion splash.

The editor presents a 21-page "Sketch of the Improvement of Medical and Surgical Science in the United States, during the last 30 years." It suffers somewhat from the fact that the editor's friends (Benjamin Rush, William Dewees, Philip Syng Physick) are given a special place in history. The author concludes that "Physiology has not advanced as rapidly in this country, as most of the other branches of medicine."

Vol 3 (1820) of *American Medical Recorder* has fresh blood among the editors. In addition to John Eberle, Granville Sharpe Pattison of Baltimore, Henry Williams Ducachet of New York, and John Revere of Baltimore have been added.

In this issue, the opening article is by Granville Sharpe Pattison (described by Osler³ as "that vivacious and pugnacious Scot") on lithotomy.

A curious notice on page 57 states that a postmortem examination was performed on a prominent gentleman of Philadelphia, apparently to lay to rest any rumors of foul play. The findings at the examination are not included. There is a brisk review of David M. Reese's *Observations on the Epidemic of 1819 in the City of Baltimore*.

The reviewer calls Reese's work "pompous bombast" apparently because Reese attacked Philadelphia medicine and public health practices. An interesting psychiatric article by Ezra Gillingham "On Erroneous Notions of Duty in Insane People" represents the psychiatric interest.

Vol 4 (1821) of the *American Medical Recorder* has articles by Davidge, Frick, John Revere, Hall and Jameson, all of Baltimore.

Dr Franklin J Didier, honorary member of the Medical Society of Baltimore, reports on the prevalent medical doctrines and hospitals of Paris. All the great French clinical teachers are mentioned. This recognition of the importance of French medicine was strengthened in the *Journal of Foreign Medical Science* in the same year. This journal, founded in 1810 as the *Eclectic Repertory*, had been concerned with English and Scottish reports, and between 1815 and 1820 with articles about Parisian medicine.

Vol 5 of the *American Medical Recorder* has only two editors: Eberle and Ducachet.

Macaulay, Zollickoffer, and Pattison of Baltimore contribute. Jameson has an article on smallpox in Baltimore in 1821 to 1822. As was the custom, articles on epidemics of infectious diseases started with the early history of the disease and followed it up to the present. No case reports are included. A defense of the health officers' use of quarantine during the epidemic is included.

Jumping from epidemiology and history of an infectious disease to a case report, Jameson has a second article on removal of a watermelon seed through a tracheostomy. The patient coughed the seed (which appears to have been lodged at the corina) out "as out of a pop gun."

Henry Staley gives an account of the bilious and intermittent fever of Frederick County Md in 1821. The description of the disease is vague and generally unsatisfactory.

The editors of the *American Medical Recorder* for Vol 6 have changed again and are made up of an "Association of Physicians in Philadelphia, Baltimore, and Norfolk."

Jameson again has several articles, one on bronchotomy. Another of his articles is on the necessity of blood-letting in yellow fever.

A "singular case of priapism" is described in which the author lapses into Latin to describe the patient's activities with his wife during coitus.

Frick and Zollickoffer are other Baltimore authors writing for this issue. Recent advances from Europe are reported. Segalas has discovered increased amounts of urea in the blood of dogs deprived of their kidneys. It is reported that the medical doctrines of Broussais have attracted con-

siderable attention in Europe. The editor promises to enter into a detailed discussion of these doctrines in future issues.

An autopsy on a patient with heart disease is reported from Dublin.

There are several articles on acupuncture in this issue.

A lecture from Philadelphia on the decline in the character of physicians is reported at great length. Ennalls Martin of Easton Md and William Hammond of Hagerstown have small contributions.

There is a review of the state of medicine during the last six months covering all specialties.

Although this volume produces little of practical importance, there is a feeling of new discovery. The new contributions of the Paris school are being identified and developed. The place of the postmortem examination in clinical medicine is being recognized. In six months enough medical advances have been made to fill 100 pages.

Samuel Calhoun has been named editor of Vol 7 which is now known as the *Medical Recorder*, the "American" having been dropped. Physicians in Philadelphia, Baltimore, and Norfolk continue to assist. Apparently the editor needed all the help he could get to keep the magazine going.

For the first time there is a series of articles on a single operation, bronchotomy, with Jameson participating. This development of specialty reporting is new, but the practitioners of bronchotomy were not specialists. Jameson wrote on yellow fever and cholera and at the same time was one of the leading surgeons of the country.

Specialities were beginning to arise, however. George Frick's "A Treatise on the Diseases of the Eye" is reviewed. The large cities and medical schools are making the practice of a specialty possible.

Davidge reviews several articles in the new *Baltimore Philosophical Journal and Review*. He selects an article on yellow fever and "Sketches of Medical Schools in Paris" as particularly interesting.

Vol 8 of the *Medical Review* (1825) has the same editorship. Jameson has a number of articles. David M Reese of Baltimore reports a case of liver disorder in a private patient. The patient, a well-to-do housewife, requested an autopsy which was duly carried out and reported.

There is a long and enthusiastic review of John Forbes' translation of Laennec's *A Treatise on the Diseases of the Chest* in which auscultation is accepted as a proved method.

Vol 10 to 15 (1826 to 1829) continue to deteriorate in interest and quality. Samuel Calhoun is replaced by James Webster as editor. Jameson continues to contribute, and becomes almost the only one to contribute original articles. Vol 12 is almost entirely devoted to reviews and abstracts of American and foreign medical journals. In Vol 13, the beginning of a new American medical journal, the *American Journal of the Medical Sciences* is announced. Five American medical journals are reviewed.

Vol 15 in 1829 announces that in the future subscribers will receive the *American Journal of the Medical Sciences*.

* * * * *

The *American Medical Recorder* ran from 1818 to 1829. Following the first volume, there was a gradual deterioration of quality, possibly owing to the development of new journals which drained off original material.

Abstracts of foreign literature were featured, an effort was made to include what would now be called basic research. The importance of the autopsy and clinical-pathological correlation seemed to be recognized in Vol 1, but was lost in later issues.

The important contribution of the Paris school was clearly recognized, but application of this knowledge appears to have been lacking in Baltimore. The beginnings of specialization are just suggested (in nose and throat and ophthalmology).

A number of Baltimore and Maryland authors contributed. Several of these reports by practitioners were on epidemics of infectious diseases in various parts of Maryland.

Baltimore authors who made more than one contribution were generally professors at the medical school who had had wide reputations in the United States.

In general, the *American Medical Recorder* reflects the state of American medicine 1818 to 1829. The culmination of this period of medical advance was represented in the case report with correlation of history, physical examination, and postmortem findings. It was in the *American Journal of the Medical Sciences* that this remarkable development took place par excellence.

What was needed for this development was not just knowledge, energy, and cases, but a hospital where experience with selected cases in sufficient number could be collected.

The *Medical and Physical Journal*, founded in 1820, also merged into the *American Journal of the Medical Sciences*.

Thomas H Wright and the American Journal of the Medical Sciences

Vol 2 of the *American Journal of the Medical Sciences* (1828) contains the first of 14 long articles by Thomas H Wright on patients studied at the Baltimore Almshouse Infirmary. The last of these articles appeared in Vol 12 in 1833. Together they form a textbook of medicine. The general form of these articles is a report of three to five similar cases, with history, physical examination, and autopsy, followed by a discussion of common features of the cases and a correlation of history, physical examination, and postmortem findings. The cases are selected so that such a correlation is possible; gross lesions were generally found at autopsy which relatively easily explained the symptoms.

Comparison of these articles through the years shows very little development of improved techniques. The history consists of little more than the chief complaint. Physical examination included percussion of the chest in only one case (where the findings on physical examination agree perhaps too well with the findings at postmortem to be purely skill).

Gross examination only of the organs was performed, but since many of the cadavers were used to prepare skeleton specimens for the students, gross examination of the bones was particularly well performed.

In Vol 2 (1828) Wright reports all cases (six) of epilepsy in the Almshouse Infirmary. There is no real statistical analysis, but there are the beginnings here of mustering common features. The history is recorded in a brief summary of why the patient was admitted. A 20-year-old man had been in the hospital since childhood with repeated epileptic fits. At postmortem examination, he was found to have a large bony spur protruding from the inner table of the skull into the right frontal lobe.

The second autopsied case was a recent admission, a blind black man admitted Aug 10, 1827 in delirium. A diagnosis of brain tumor was made. At postmortem examination a large pituitary tumor pressing on the optic nerves was found.

When the skeleton was cleared of muscle, many osseous abnormalities were noted. The dura was calcified, cervical vertebrae 1, 2, and 3 were completely ankylosed. The sacroiliac bone was solid with no evidence of a joint.

In Vol 3 (1828) Wright describes a woman admitted on Nov 14, 1827 who fell down the stairs one week before admission and suffered complete paralysis of her arms and legs. She was kept at

home for a week, during which time she had no bowel movements, but urine flowed freely and without control.

Examination in the hospital showed a slow soft pulse, unembarrassed respiration, and an alert patient. The abdomen was tense and tympanitic, but was not painful. The neck was swollen. A diagnosis of subluxation of C5 on C6 was made.

She had two severe spasmodic attacks, violent enough to throw her out of bed. She began to vomit repeatedly; the vomitus finally became fecal.

She was treated with Croton oil and had an alvine bowel movement, but died on the fourth day.

Postmortem examination showed partial dislocation with fracture of C5-C6; and a large hematoma.

There are several cases of hip disease described; one of aseptic necrosis of the femoral head which took place over a two-week period; one whose hip passed through the acetabulum into the pelvis; and finally a case of dislocation of the hip after an infection of the joint. In describing this case Wright gives a vivid picture of ward rounds, the interchange of opinion with the attending students, and also an insight into the thoroughness of the history of the present illness:

"The second week after Callender had been discharged from clinical regimen, he attracted my attention while passing his bed, on which he had lain down to rest for the moment, by inquiring if something could not be done for the more complete extension of his leg, which remained somewhat contracted. I threw back the bed covers to observe the state of the leg, and was immediately struck with apprehension that there existed an evil in the case, which I had never before suspected; the remarkable relation of the right knee to the left, in the position the young man lay, at once excited my fears that there was serious mischief at the hip. The lad was on his back, with both limbs drawn up, and the patella of the right presented three inches short of the left. Observing that the pelvis was depressed on the left side, I caused the obliquity to be corrected, and finding that the right knee did not descend to the left leg by two inches, I expressed to the class, the attending pupils, my conviction that the head of the femur had lost the acetabulum. Passing round the bed to examine the hip, and removing all dress from the part, dislocation was manifest, almost without proof of touch . . . It was minutely investigated whether the hip had been hurt by a fall, by jumping, a strain, blow, etc on the part. Those ques-

tions had been made in a general manner before, and were answered then as now, in the negative."

Vol 3 contains a report on four patients who suffered sudden death. Wright notes that sudden death occurs commonly in dropsy, especially when there is a pleural effusion. Why is pleural effusion so common? Is it pressure on the heart by the effusion or on the lungs that causes the sudden death? These factors may play a part, but it has been found that sudden death occurs after the effusion has cleared.

"Ossification of the valves of the heart or of the coronary arteries has been found in some cases, and a general argument has been deduced . . . as the true cause of sudden death."

Cases of orthopnea, anasarca, and severe ascites are reported in which sudden and unexpected death occurred after the patients had recovered from their initial symptoms.

Vol 4 also contains two long clinical-pathological reports by Wright from the Almshouse Infirmary. The first was a report on erysipelas which noted that there had been an increased incidence over the preceding 15 months, but never more than two or three at a time in the Almshouse. The cases arose in different parts of the institution and there was no significant reason to believe they arose from contagion. No cases had been seen elsewhere in Baltimore, so that the cause of the disease must be some local disorder such as a miasma at the Almshouse.

The second report by Wright includes a series of six cases of various sorts. One appears to have had tuberculous pericarditis. One case was of Cyanche Laryngea in which the patient had severe swelling of the larynx, difficult breathing, and loud laryngeal stridor. "It was but to look at the patient's struggles for breath, to have the expedient of tracheotomy suggest itself for adoption." Instead the patient was treated with cupping, with prompt recovery.

One case reveals not only the extent of the history, the first mention of stethoscope in Wright's reports, and the extent of autopsy. The stethoscope was an instrument brought into use for the special case only. Further, the reason for death was clearly revealed from the postmortem examination. The final episode, with severe coughing preceding vomiting was explained by rupture of an aneurism into the trachea, followed by filling of the esophagus and stomach with blood through a tracheo-esophageal fistula.

Other articles in this issue of the *American Journal of the Medical Sciences* were by Pierre Louis on Typhus and an article by Elisha Bartlett on the hospitals of Paris.

In Vol 5, Wright reports four cases: One was a transfer from the Baltimore Infirmary which was the hospital for the University of Maryland Medical School at Lombard and Greene streets. This is the first mention of a transfer between two hospitals in Baltimore, and the reason for the transfer has a modern ring.

"He entered the Baltimore Infirmary, and underwent various treatments, but having exhausted his means of paying the very moderate charge of that institution for board and medical aid, and his disease continuing, he came to the Almshouse."

This patient had a history of stomach pain, vomiting, and weight loss. Examination showed only epigastric tenderness. Postmortem examination was normal except for the stomach which had a uniform thickening of its wall to one half inch. This change was identified as a scirrhus stomach growth.

The fourth patient had a "concretion" in the right atrium suggestive of a myxoma or thrombus. Three students of the house, Smith, Warner, and Glassell are mentioned.

Wright's "Observations on the Treatment of Delirium Tremens, and the Use of Warm Baths in that Disease" is the lead article in Vol 6 of the *American Journal of the Medical Sciences*. He reports his treatment of delirium from intemperance uniformly successful for two years.

He had tried a number of methods of treatment including very high doses of opiates. He had heard that patients benefited from eating spider webs, but he was unable to confirm this observation in two patients. His usual treatment was to use warm baths, liberal cupping of the abdomen and head, and small doses of opiates. A number of methods of restraining delirious patients had been tried, and he had adopted the method of chaining the patient by a leg to the bed as the safest and easiest method.

He concluded that there was no evidence that administering alcohol was necessary in the treatment of delirium tremens. He notes that the Baltimore Almshouse during 1829 used 48 gallons of wine, two barrels of whiskey, seven gallons of gin, six gallons of spirits, and two gallons of French brandy. These spirits were used mainly for making tinctures, formulations, and liniments. None was administered to patients as a beverage.

A second article by Wright in the same volume is concerned with "the use of Warm baths in Season Fever, commonly called "Bilious, Bilious typhus, etc."

These fevers occurred in increased numbers in the Almshouse in September, October, and November 1829 at a time when a railroad line and canal were being built near the Almshouse. Wright's article is a series of questions to the three students (R J Thompson, A F Glassell, A L Warner) working in the Almshouse. Each student answers a series of questions about the patients with bilious typhus whom he had treated. All agreed that warm baths had helped the fever patients most consistently. Cupping was the most effectual local treatment. This article reveals that the students were intimately involved with the treatment of patients, but were closely supervised by Wright. They had some leeway in method of treatment, but it is clear that they were following Wright's suggestions as to treatment very closely.

Vol 6 contains a synopsis of all clinical knowledge about the heart at that time. Corvisart's work and John Forbes' translation of Laennec are featured. This article is one of the earliest on a subspecialty within Internal Medicine.

A case report on a fistulous communication between the vagina, bladder, and rectum is reported from the US Arsenal near Baltimore (Pikesville) by Charles Byrne.

In Vol 7, Wright describes the use of percussion of the chest for the first time and correlates the findings with postmortem examination. He reports a case of liver disease and a lung abscess, possibly Laennec's cirrhosis and tuberculosis.

Vol 8 of the *American Journal of the Medical Sciences* contains Wright's reports having to do with meningitis, cerebritis, cerebral congestion, subdural hematoma, and possibly a ruptured carotid artery aneurism. These conditions are differentiated clinically and pathologically (grossly) and the article would have made an excellent chapter on infectious and vascular diseases of the brain in a medical textbook of the day.

Several practices of the Almshouse are revealed in the case reports. Students went on call around the clock. An insane patient got loose and killed another patient, probably by brain damage and subdural hematoma.

In the same issue Charles Bell reports a case of ruptured artery in the brain.

Charles Caldwell's prize essay for the Medical and Chirurgical Faculty of Maryland on Malaria is published.

There is an article on the principles of the new medical doctrine of observation at the bedside and in the dissecting room as described by Broussais of Paris.

Vol 9 contains two articles from Baltimore Md, one by Thomas Wright from the Almshouse Infirmary reporting abnormalities of the external genitalia and one by E Geddings (Professor of Anatomy in the University of Maryland and one of the Surgeons to the Baltimore Infirmary) on asthenia, debility, and weakness.

Vol 10 (1832) of the *American Journal of the Medical Sciences* contains Thomas Wright's Report to the Trustees on the State of the Medical Department of the Baltimore Almshouse Infirmary for the year ending April 30, 1831; 2,500 cases were treated; 2,000 were relieved or cured, and 286 died; 200 to 300 remained in the "hospital" at the end of the year.

Of the 286 deaths, ten died on the day of admission, four were stillborn, and 85 had confirmed phthisis when admitted making a total of 99 with "necessarily fatal" diseases on admission. When one considers the late stage that tuberculosis had to reach before the diagnosis was suspected, and before hospitalization was resorted to, it is not surprising that these cases of "confirmed phthisis" were considered "necessarily fatal."

A new disease seen first in November 1831 was Hospital Gangrene. Forty cases were seen since then; 19 were saved. The disease is described and measures used to combat it outlined. The surgical ward at the Baltimore Almshouse at Calverton was on the third floor in a room 80 by 40 feet with a 16-ft ceiling. It was well lighted and ventilated by 18 windows. The patients on this ward had leg ulcers, wounds, and fractures. There were 60 to 80 single beds. The beds were cast iron with a plank bottom covered with hay or straw, frequently changed. Coarse linen and blankets were used as cover. The floors were scoured weekly, and the walls whitewashed five to six times yearly. All patients were washed and their clothes changed on admission.

Just what hospital gangrene was is not clear. It was to appear in the Crimean War and in the American Civil War among the Sharpsburg wounded at Frederick late in 1862. It was believed then as by Wright to be "contagious and infectious." W W Keen considered it a streptococcus infection. Others thought it might be diphtheria or gas bacillus or a mixed infection. Among the students performing "arduous duties diligently" this year at the Almshouse were M Henry, J B Stephen, W A Selden, W Price, and W Yates.

Thomas H Wright's last contribution from the Baltimore Almshouse Infirmary appeared as lead article in Vol 12 of the *American Journal of the Medical Sciences* and was entitled "Contributions

to Cardiac Pathology." There is a case of aneurism of the aorta with loss of left radial pulse and later return of the pulse. A remarkable dilation of subcutaneous veins over the left side of the trunk appeared over the period of a few weeks. The aneurism finally ruptured into the heart; at postmortem examination, the findings are very suggestive of a subclavian "steal" syndrome with the left axillary artery completely blocked but receiving its blood supply from beyond this obstruction.

There are two cases of pericarditis, a patient with possible aortic valve disease, and Stokes-Adams attacks. There is a discussion of coronary flow.

Case 5 appears to have had tricuspid disease with abnormal jugular pulsations.

Summary

A study of the contributions made by Maryland physicians to the Medical Literature between 1797 and 1833 reveals clearly the emergence of the scientific method and its application to the study of patients. Early reports represent merely the opinions of physicians presented without supporting evidence. The major diseases of interest were the febrile diseases which were thought to be caused by disorders of the humors. By 1830, a well-organized method of approach incorporating history, physical examination, laboratory data, clinical-pathological correlation, and analysis of similar cases was well established. The idea that diseases started in individual organs had become well established.

Hospital teaching of medical students with intensive study of each case and daily ward rounds is taking the place of preceptorships. The use of instruments such as the stethoscope for the study of patients is described.

These developments represent the basic application of the scientific method to medical practice. The first written medical reports from Maryland describing this method clearly were written by Thomas H Wright and published in the *American Journal of the Medical Sciences* in 1828. We have called the period from 1828 to the present Period III (Scientific Method in Medicine).

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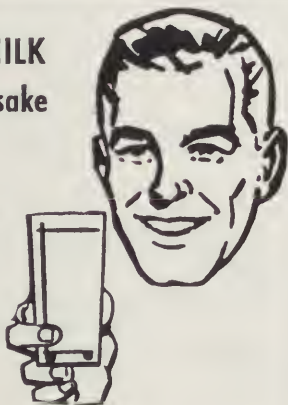
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USE OF A RESPIRATORY WEANING SCORE

PETER CHODOFF MD

PETER M S MARGAND MB, BChlr, FFARCS

Dr Chodoff is Anesthesiologist-in-Chief, Baltimore City Hospitals. He is also Associate Professor of Anesthesiology at Johns Hopkins University School of Medicine, as is Dr Margand.

Information and reprint requests to Dr Chodoff at Baltimore City Hospitals, 4940 Eastern Ave, Baltimore Md 21224.

Weaning a patient from multiple aids including mechanical ventilation, enriched oxygen environment, humidification, etc is a difficult and complex task. There are numerous schemes that describe the organization of data used in respiratory care.¹⁻⁵ This report describes our scoring system, its use, and the flow charts used with it.

Once the primary condition responsible for the mechanical ventilation has improved enough for an attempt at weaning to be made, it is helpful to have an organized systematic system for its implementation. Weaning in this context is defined as a progressive step-by-step disengagement from the multiple respiratory aids used in treating these patients.

Table 1 lists 16 variables divided into three categories: I) Oxygen Exchange, II) Carbon Dioxide Exchange, and III) Mechanical Efficiency. Each of the scores listed under one point are below critical values to begin weaning, those listed under two points are minimal values for beginning weaning, and those listed under three points are close to normal values. For a valid score, there should be at least two parameters representing somewhat different aspects of the reserve functions of each of the three categories in

TABLE I

Variables	Points		
	1	2	3
I. OXYGEN EXCHANGE			
1. PaO ₂ on 40% O ₂	≤ 60	≤ 70	≥ 75
2. (A-a) DO ₂ on 100% O ₂	≥ 300	≥ 250	≤ 200
3. (A-a) DO ₂	≥ 2.0	≥ 1.0	≤ 0.8
4. $\frac{\text{PaO}_2}{\text{Qs}} \div \text{QT}+$	≥ 20%	≥ 15%	≤ 10%
II. CARBON DIOXIDE EXCHANGE			
5. PaCO ₂	≥ 60	≥ 55	≤ 50
6. VD/VT	≥ 0.6	≥ 0.5	≤ 0.4
7. pH (on respiratory basis)	≤ 7.30	≤ 7.35	≥ 7.40
8. Base Excess	+ 7	+ 5	+ 3
III. MECHANICAL EFFICIENCY			
9. Resting Tidal Volume cc/kg body weight	≤ 4	≤ 5	≥ 5.5
*10. Maximum Eff Resp Vol Resting Tidal Volume	≤ 1.5	≤ 2.0	≥ 3.0
**11. Effective Compliance	≤ 30	≤ 40	≥ 45
***12. VC/PVC x 100	≤ 25	≤ 30	≥ 35
13. Inspiratory Force	≥ -20	≤ -25	≤ -35
14. Respiratory Rate	≥ 35	≤ 30	≤ 25
****15. Bronchospasm	++	+	0
****16. Secretions	++	+	0
* This ratio is not valid unless resting tidal volume is at least 4 ml/kg body weight.			
** Effective compliance = $\frac{\text{Tidal Volume}}{\text{Peak Airway Pressure}}$ measured on a ventilator			
*** Per cent of predicted vital capacity			
**** ++ = moderate + = minimal 0 = absent			

Table 1. An overall score of 2.0 is necessary to begin weaning and also for progressing to each subsequent step in the weaning process.

An example of a sample computation and use of the Respiratory Weaning Flow Chart (Table 2) which is used with the scoring system is outlined in Table 3.

These six variables would be entered on the left side of the flow sheet in Section I. The score for each variable is calculated from Table 1 and entered in the corresponding box (1) on the right side of the flow sheet. The total score under each classification is the sum of all scores for this category. The mean score for each

NAME	John Doe					HT.	62"	WT.	140	SEX	M
VARIABLES RECORDED					SCORING						
	1	2	3	4	5						

category is the total score divided by the number of variables in the category. The overall score is the sum of the mean scores divided by three.

Each patient who enters the ICU has their age, sex, height, and weight recorded at the top of the flow chart. From these measurements are obtained the predicted values for vital capacity and tidal volumes which are used in scoring variables #9 and 12.

When weaning a patient from a ventilator, records of pulse rate, blood pressure, and state of consciousness should also be kept. Deterioration of any of these parameters may be an indication to reinstitute

mechanical ventilation.

There are several areas of modification of the scoring systems for particular patients: 1) compensated chronic hypercapnea affects variable #5; 2) carbon dioxide production is increased with fever, shivering, restlessness, increased catechol amines, burns, and infection. These conditions require an increase in minute ventilation. Variables #6, 9, 10, 13, and 14 are scored more stringently depending on the magnitude of the above conditions present in the patient. The remarks section, in the lower left corner of the respiratory weaning flow chart, should include any statement about the modifying conditions listed above and the specific alterations made in the scoring for a particular patient.

In summary, we 1) keep an accurate record of the 16 variables listed in Table 1 on our respiratory care flow sheet; 2) commence each new step in the weaning process when a score of two or more is obtained, eg, 5 minutes/hour off ventilator on a "T" piece; 3) rescore the patient before proceeding with the next step in weaning, eg, 15 minutes/hour off ventilator, etc; 4) take into account the effects of age, cardiac disease, and the other conditions listed above when scoring; and 5) never begin weaning after 4:00 PM.

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TABLE 3

Variables		Points	Mean
I. PaO ₂ (0.4 FIO ₂)	= 60	1	
(A-a) DO ₂ (1.0 FIO ₂)	= 240	2	1.5
II. PaCO ₂	= 58	1	
VD/VT	= 0.4	3	2.0
III. VT cc/kg	= 5.0	2	
Effective Compliance	= 50	3	2.5
Respiratory Weaning Score = $\frac{1+2+1+3+2+3}{6} = \frac{12}{6} = 2.0$			
or			
Respiratory Weaning Score = $\frac{1.5 + 2.0 + 2.5}{3} = \frac{6}{3} = 2.0$			



O'DONNELL INFIRMARY—The Maryland Training School for Boys was the scene of the dedication of the Dr Charles F O'Donnell Infirmary. Nearly 100 friends, neighbors, relatives, and interested citizens attended the ceremonies on a beautiful Saturday afternoon (April 14) high on a hill in Baltimore County. Dr O'Donnell is pictured beside the plaque after the dedicatory exercises. The new building, conceived over ten years ago, was finally brought to fruition this year. It contains separate quarters for ill inmates, as well as a "holding center" for violently disturbed persons.

Dr O'Donnell has served as medical director of the Training School through three administrations and for nearly 30 years. During this time, he has improved on-site services provided to residents, including a comprehensive psychiatric evaluation system and continuing care through Sheppard-Pratt Hospital.

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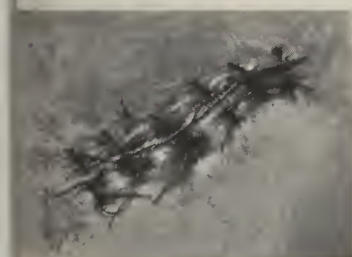
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Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide,' check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides

are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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ROBERT E FARBER MD MPH
Commissioner

Baltimore City health department

Child Lead Poisoning Project Progress Report

The City Health Department's Child Lead Poisoning Project is now under way with 15 of the Department's 35 child health clinics screening preschool youngsters for lead paint poisoning. Starting with one clinic in the Southeastern Health District January 29, the project is now screening approximately 200 children per week substantially in all areas of the City.

As of April 6 a total of 1,088 children had been tested in City Health Department clinics and 32 youngsters, 20 months to six years, had been found with elevated blood leads. The record also shows 38 additional city children with high lead levels detected by other medical resources. Three children have been confirmed as clinical lead poisoning cases.

A walk-in clinic was opened in the Druid Health District Building, 1515 W North Ave early in May. It is for children not seen in established child clinics in the Health Department or elsewhere in the City. Another walk-in clinic will be established in the near future.

The City's expanded lead detection and prevention program has been made possible by a \$150,000 grant from US Public Health Service with matching City funds of \$76,600. In addition to the Project Coordinator and clinic staff, four specially trained health aides are helping to enlarge the scope of home inspections and community education.

Concerned with citizen involvement, the Department on January 10 convened a Citizens Advisory Council on Lead Paint Poisoning in Children. This group will serve to advise the Commissioner of Health on matters related to lead poisoning activities and aid in the community aspects of the program. On April 7 a further step in sparking community interest was a "Lead Poisoning Awareness" seminar held by the

Women's Auxiliary to the Monumental City Medical Society at Provident Hospital. Guest speakers were Dr J Julian Chisolm, Johns Hopkins School of Medicine; Dr Oakley Saunders; and Mr William R Smith, Lead Project Coordinator, Baltimore City Health Department. Chairman of the seminar was Mrs Vincent R Blake. This organization has made child lead poisoning its number one project for the next three years and members will serve as volunteers in the walk-in clinics when established.

Informational pamphlets on child lead paint poisoning may be obtained by calling the Bureau of Health Information, phone 396-4399.

Park Heights Health Center Opened

A new neighborhood health center has been opened in Northwest Baltimore through the joint efforts of the Northwest Baltimore Corporation, the Northwest Health Services Inc, and the Baltimore City Health Department. Services for residents include a preschool child health clinic, family planning, and dental care.

This new Park Heights Community Health Center is located in the New Elizabeth Baptist Church, 4901 Park Heights Ave. The installation has two waiting rooms, four interviewing rooms, four examining rooms, a laboratory, a supply room, a business office, and an office for the Druid Health District Public Health Nurse Team 6—a group of seven public health nurses and two health aides who serve this Park Heights area community.

The Child Health Clinic relocated from the Enoch Pratt Branch Library, Garrison and Park Heights avenues, is open Thursday at 9:00 AM and Tuesdays and Fridays at 12:30 PM.

The Family Planning Clinic is open Mondays at 12:30 PM. Both child health and family planning services are free and by appointment only.

For appointments call 542-4333.

The dental clinic, a new low-cost service for area residents, is provided Monday through Friday from 9:00 AM to 5:00 PM by the Northwest Health Services Inc, a nonprofit agency developed by the Northwest Baltimore Corporation. Its Board of Directors includes the President, Mr Joseph Bernard, 12 area residents, and six staff professionals from Sinai Hospital, Provident Hospital, and the Baltimore City Health Department. The dental clinic is operated by a co-operating private dental group. In addition to treatment, the clinic will place emphasis on preventive dentistry and health education.

The new health center is one of several accomplishments attained by the Northwest Baltimore Corporation, established in 1968 and funded by the United Fund's Project PUSH (Project Urban Self Help). This community organization, serving 75,000 residents in the area above Park Circle to the City line and extending to Jones Falls on the east and the Western Maryland railroad tracks on the west, works closely with the City Health Department's Sanitary Enforcement Division in maintaining the neighborhoods; has helped bring three new schools to the area, and is planning two more mini-schools; organizes and encourages neighborhood cooperation; sponsors a Youth Service and Referral Bureau with grant funds from the Governor's Commission on Law Enforcement and the Administration of Justice; and is currently involved in the revitalization of the area adjoining the proposed New Town Cold Spring development.

President of Northwest Baltimore Corporation, 5111 Park Heights Ave, is Mr Clarence A Cox. Executive Director is Mrs Margaret Pollard, formerly health educator with the Baltimore City Health Department. Information on any of the above projects may be obtained by calling Mr Richard T Marks, Health Coordinator, phone 644-5265.

Mary Louise Pierre

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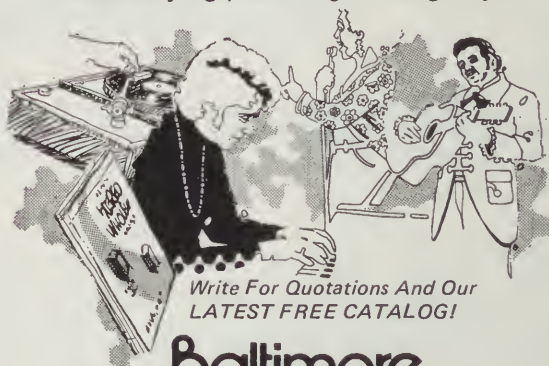
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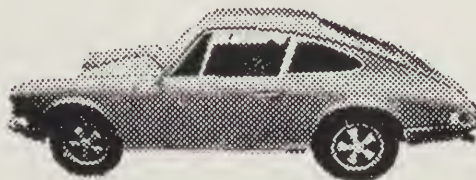
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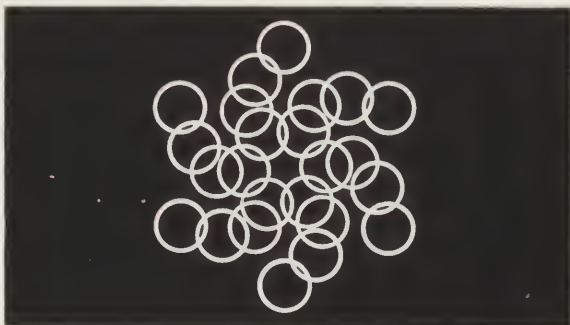
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From the Subcommittee on Alcoholism of the
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alcoholism section

ANTABUSE, 1973

G DOUGLAS TALBOTT MD
OLIVIA GANDER MA

Dr Talbott is Medical Director and Olivia Gander the Educational Resources person for the Baltimore Public Inebriate Program.

Information and reprint requests should be directed to Dr Talbott at PO Box 1482, Baltimore Md 21203.

References

A complete list of the 24 references in this paper may be secured from Dr Talbott.

Abstract or Summary

Both current and accumulated evidence indicates that Antabuse, taken at conservative dose levels, is a safe and useful adjunct to the treatment of chronic alcoholism in the patient who is both informed and cooperative.

Taken alone, with care to avoid exposure to synergistic compounds, Antabuse rarely elicits either serious or prolonged side effects. But Antabuse does act dangerously to inhibit the bio-transformation of certain other substances such as diphenylhydantoin, isoniazid, warfarin, metronidazole, the fungus *Coprinus atramentarius* or "inky-top" mushroom, animal charcoal, and particularly alcohol; even the fumes of cyanide and formaldehyde may provoke a toxic reaction in the Antabuse-treated patient.

Antabuse dosage usually begins at 0.5 gram daily and after a period of time may be reduced to 0.25 gm daily for maintenance. Some success has been reported for subcutaneous implantation of the drug, which makes a single dosage effective for up to six months and provides time for more definitive forms of therapy to be applied to outpatients.

An attitude of cooperation on the part of the patient is perhaps the most important single factor in the success of Antabuse as an adjunct to the treatment of alcoholism.

Chemical Identification and Therapeutic Use

Antabuse is a trade name for disulfiram, which is a highly purified form of an ethyl congener chemically identified as tetraethylthiuram disulfide.¹ Other trade names are Abstynyl, Averson, and Refusal. In this paper we will hereafter refer to the drug as disulfiram.

The only known therapeutic use for disulfiram is as an adjunct in the treatment of chronic alcoholism.² By greatly "sensitizing" the disulfiram-treated patient to the toxicity of ethanol he is discouraged from the ingestion of alcoholic beverages.

History

Disulfiram as a therapeutic agent has a rather interesting history. Its first use was industrial, as an antioxidant in the processing of rubber. It was casually observed that workers exposed to disulfiram soon developed an acute intolerance for alcohol. As early as 1937 it was informally suggested that the substance might be of use in treating chronic alcoholism³ but no formal reports of its effect on human subjects appeared, and the suggestion was neglected.

Nearly ten years later disulfiram was investigated for its possible use as an antihelminthic. During this process, two Danish physicians, Drs Hald and Jacobsen, took some of the drug, and subsequently both experienced unusual and unpleasant symptoms after indulging in alcoholic beverages at a cocktail party.^{4,5} They were quick to associate their unaccustomed reaction with their prior ingestion of disulfiram. This time observation of the disulfiram-alcohol reaction led to controlled experiments which established that disulfiram greatly increases the average subject's sensitivity to alcohol, and thus constitutes a chemical agent capable of providing pharmacological reinforcement for a patient's desire to stop drinking.

Disulfiram-Alcohol Reaction

Within approximately 12 hours after an initial dose of one tablet (0.5 gm) of disulfiram, and for a period up to 12 days after the most recent dose the disulfiram-treated patient responds to even a small quantity of alcohol (as little as 7 ml alcohol in some susceptible persons, according to Goodman & Gilman),⁵ with one or more of a variety of circulatory and gastrointestinal symptoms. These symptoms range in severity from the discomfort of a hot, flushed face, a mild headache, and/or transient nausea, through extreme redness of the upper extremities, the thorax, and even the abdomen, accompanied by a throbbing headache, blurred vision, and/or violent vomiting.^{5,6}

Ingestion of greater amounts of alcohol may result in disorientation, respiratory difficulty, cardiac dysrhythmia, myocardial infarction, followed by symptoms of severe shock.

Between these extremes may appear such signs and symptoms as bloodshot eyes, swollen lower lids, a dryness of the throat which provokes continuous coughing, excessive sweating, great thirst, chest pain, weakness, vertigo, orthostatic syncope, alterations in both ECG and EEG, convulsions, and psychoses.⁷

The disulfiram-alcohol reaction persists from approximately 30 minutes to several hours,⁸ and generally terminates in an exhausted sleep from which the patient awakes without further ill effects.³ However, the reaction can be critical. For example, rupture of the esophagus has been recorded when excessive drinking provoked violent vomiting.^{9,10} Psychoses, if present, may be greatly intensified.¹¹ Despite these possibilities, the disulfiram-alcohol reaction is said to be only rarely fatal, even in cardiac patients. Rothstein, in a letter to the editor of a New England medical journal states that a review of the literature disclosed more than 70 documented cases of cardiac disease in which chronic alcoholism was treated with disulfiram without death or serious complications.¹² He also notes that neither death nor long-term ill effects have resulted from disulfiram in a series of 1,500 chronic alcoholics who have been observed by him during treatment. Lundwall notes that a list of reported complications, accidents, and fatalities due to Antabuse, compiled 1948-1961, numbered only 100.¹³

Duration and severity of the disulfiram-alcohol reaction appear to depend on several considerations. The prior dose and individual accumulation of disulfiram, the amount of alcohol subsequently ingested, and the length of the interval between disulfiram and alcohol are obviously important. Individual differences in biochemical

activity,^{5,14} and even the personality of the patient⁵ are also suggested as being factors which help to determine the body's response to alcohol during Antabuse therapy.

In some instances, mere physical contact with alcohol is all that is necessary to trigger a reaction. In 1971, Rothstein reported two such cases from a recent series of patients in an alcoholism treatment program.¹⁵ One reaction resulted from the application of eardrops containing alcohol during treatment of a perforated eardrum. Another resulted from the use of a nebulizer containing alcohol during treatment of an acute attack of asthma.

Individual differences in the disulfiram-alcohol reaction vary in both magnitude and persistence. Thus one patient may be able to take disulfiram within a few hours after alcohol without any apparent reaction, while another may exhibit mild symptoms even though an interval as long as three days has occurred. One may be able to resume drinking within a week after his most recent dose of disulfiram, while another may require up to 12 days before he can again drink without symptoms of reaction.^{5,14}

Probable Mechanism of Action

The mechanism by which disulfiram so dramatically potentiates the toxic effects of alcohol is not yet fully understood. It seems generally agreed that disulfiram interferes with the intermediate metabolism of alcohol,^{2,3,5,7,8} delaying its biotransformation until critical levels of one or more toxic byproducts accumulate. The drug probably competes for the enzyme aldehyde dehydrogenase,^{3,7,8} but it also interferes with many of the other hepatic enzymes which are active in the metabolism of alcohol.²

An experiment reported by Vesell in 1971 demonstrates that disulfiram itself alters both antipyrine and catecholamine metabolism.¹⁴ Such activities would provide a mechanism capable of interfering with the action of drugs other than alcohol and sometimes dangerously potentiating such medications as warfarin, for example.

The liver is probably the most important site for the detoxification of alcohol. In animal experiments, subtotal hepatectomy rendered the subject more likely to succumb to the toxic effects of disulfiram, pointing to the importance of that organ in reducing the toxic properties of disulfiram.⁵ Therefore, the concept of competition between disulfiram and alcohol for the detoxifying activity of multiple enzymes, ending in a stalemate and a consequent build-up of toxins from both sources, provides a reasonable theory of mechanism.

Still unexplained are reactions which seem

diametrically opposed. For example, why does the disulfiram-alcohol reaction produce hypertension in some patients,⁷ and severe hypotension in others?³ Can this be explained on the basis of individual differences in cardiovascular status prior to medication, or of individual biochemical reaction to either of the drugs alone or to the synergistic effect of the combination?

There is yet much to be learned about the mechanism of the disulfiram-alcohol reaction.

Effects of Disulfiram Alone

Of itself, disulfiram appears to be generally well tolerated by man. Single doses up to 6 gm have been reported without ill effect, and daily doses ranging from 0.25 to 0.75 gm have been taken for months, even years, without obvious reaction.⁵ Fox reported a patient on disulfiram for 14 consecutive years with no apparent harm.¹¹

There are exceptions. Some subjects do experience uncomfortable side effects, but these are rarely prolonged or severe, provided the dosage remains within reasonable limits, such as 0.5 gm or less. Opinion is divided as to whether a mild skin rash⁵ or drowsiness¹ is the most common reaction. Antihistamines generally control the rash;⁵ taking disulfiram at bedtime rather than in the morning obviates the possible annoyance from drowsiness. Other reported reactions include lassitude, fatigue, tremor, restlessness, reduced sexual potency, headache, dizziness, an unpleasant taste in the mouth, and mild gastrointestinal symptoms.^{5,7} If initially normal, neither the ECG, the EEG, nor the psyche appears to be affected by disulfiram in moderate doses, but pre-existing abnormalities may be accentuated by the drug.⁵ Complaints of irritability and insomnia occasionally follow the initial dose, and psychotic reactions have been noted.^{1,7}

Excessive dosage may result in more severe symptoms. One patient who had taken a nightly dose of 0.25 gm for several weeks, without ill effect, of his own initiative suddenly increased the dose to 0.5 gm taken two or three times daily; the result was acute brain syndrome, peripheral neuropathy, and transient parkinsonism.¹⁶ He recovered without residual effect when the dosage was stopped.

All unpleasant signs and symptoms tend to recede quickly when the dosage is reduced, and totally disappear when it is withdrawn.^{5,7} Often a reduction of dosage can be achieved without sacrificing the intended effect of the drug, since disulfiram-induced sensitivity to alcohol tends to increase during the early days of therapy and stabilize after a few weeks of continuing medication.¹

It is possible, even probable, that some of the

side effects imputed to disulfiram alone could more properly be ascribed to either 1) the withdrawal of alcohol, 2) the surreptitious but deliberate ingestion of small quantities of alcohol, or 3) an unrecognized exposure to alcohol in the form of other medication, food, or cosmetic preparations.⁵

Administration and Dosage

When disulfiram was first used in the treatment of chronic alcoholism it was considered necessary to hospitalize the patient for a few days before initiating therapy^{1,5,6} to ensure that he had abstained from alcohol for at least four days. He then remained in the hospital during regulation of dosage and planned experience with the disulfiram-alcohol reaction, procedures which often required more than two weeks. If greater speed was important, the initial dosage was raised to 2 gm daily and scaled downward until it was leveled off at 0.5 gm on the fourth day.¹ Dosage was regulated by test drinks of alcohol to the point where discomfort resulted within 20 minutes after a half-ounce of 100-proof spirits, or the equivalent thereof, was ingested.^{1,5,11} If especially severe reactions occurred, hospitalization made it possible to provide effective treatment.

These procedures often resulted in unnecessarily negative, if not actively hostile, attitudes toward disulfiram therapy on the part of the patient. Furthermore, the early popularity of the drug led to its over-enthusiastic prescription by some members of the medical profession and its occasional abuse by the patient; both resulted in severe and wholly avoidable reactions, as well as an occasional fatality.¹⁰

Today, after much more experience with disulfiram, the medical attitude has changed.^{11,12} It has been demonstrated that the clinical course is no better after severe reaction than after mild responses.⁶ It was found that conservative dosage of 0.25 to 0.5 gm have virtually abolished severe symptoms in the great majority of patients;^{11,13} greater care in choosing the patients, and careful instructions to cooperative subjects, obviate the need for provoking instructive reactions. After the behavior and purpose of disulfiram have been explained, the patient is given the responsibility for avoiding alcohol for a minimum of 12 hours before the first dose of disulfiram, and for a conservative ten days after the most recent dose.¹⁷ Selection and instruction of the patients to be treated, and conservancy of dosage seem to be the best insurance for the success of disulfiram therapy.^{6,11,18}

Instruction of the patient must emphasize the considerable danger from the deliberate ingestion

of alcohol within the vulnerable period created by disulfiram. It should also warn of the possible discomfort arising from the inadvertent exposure to alcohol by ingestion of sauces and other foods containing small amounts of alcohol, and by contact with alcohol hidden in cough syrups, body lotions, etc, though these hazards are greatly minimized, if not negated, by the low dosage level currently recommended.

Some work has been done on the subcutaneous implantation of disulfiram at six-month intervals. Paillot¹⁹ and Hussain²⁰ praised this method of treatment as a means of making the patient available for other types of long-term therapy. Kellam reported its successful use in a 51-year-old man who had 15 previous hospitalizations within a ten-year period.²¹

Selection of Patients: Contraindications

It was formerly thought that several rather common medical conditions contraindicated the use of disulfiram: coronary heart disease, cardiac decompensation from any cause, asthma, diabetes mellitus, pregnancy, psychoses, any form of liver or kidney disease.^{1,5,6} Today, disulfiram may be given in the presence of virtually any of those conditions;^{11-13,22} their existence merely emphasizes a need for more accurate appraisal of the patient's physical and psychic states, and more careful attention to the adjustment of dosage. Whatever disease state concurrently exists, the attending physician must weigh the risks of disulfiram therapy against the risks of continued drinking of alcohol, provided one single condition is established: the patient's sincere cooperation.

The success of disulfiram as an adjunct to the outpatient treatment of chronic alcoholism probably depends more on the patient's attitude than on any other single factor.^{11,23} Unless he is completely willing to cooperate, to follow the dosage schedule faithfully, he can (and probably will) find countless ways to sabotage the regimen of

therapy.^{1,11} In many instances, the more closely the outpatient is supervised during dosage, the more greatly does he feel challenged to circumvent such supervision. His subsequent relapse into drinking he then mendaciously refers to the failure of the medication.

Cautions and Comments

Since disulfiram is known to interfere with the metabolism of certain other compounds, notably alcohol, warfarin, diphenylhydantoin, isoniazid, and possibly many not yet recognized,^{8,14} it is imperative that the attending physician be well aware of concurrent medication before he prescribes disulfiram. An otherwise safe amount of disulfiram could dangerously potentiate the accustomed dose of another medication, or unexpectedly trigger a toxic reaction. It is possible to combine disulfiram with the use of other synergistic compounds, provided both dosages are modified with caution. Rothstein reported successful combination with warfarin in 1968;²⁴ using the same technique he was later able to treat an alcoholic with severe liver disease and a tuberculous kidney and already on a regimen of rifampin and isoniazid.²² The important factor is to be aware of the concurrent medication and of the possibility of the potentiating behavior of disulfiram.

A candidate for disulfiram therapy must abstain from alcohol for a minimum of 12 hours before his initial dose of the medication; furthermore, he must have a good understanding of the reason for such abstinence. He must be aware of the possible effects of ingesting, or even contacting alcohol in any guise within a period of at least four days after his most recent dose of disulfiram. He must also be made to realize that the purpose of the medication is only to reenforce his own intention to abstain from drink; not in itself to prevent his drinking. The basic choice, whether to drink or not, must clearly be that of the patient himself.

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DANIEL V LINDENSTRUTH MD
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the heart page

CONGENITAL HEART DISEASE IN THE NEWBORN

Part 2: Medical and Surgical Management

ROBERT L GINGELL MD
DANIEL R PIERONI MD

Dr Gingell is with the Department of Pediatrics, University of Maryland Hospital.

Dr Pieroni is Assistant Professor of Pediatric Cardiology, Johns Hopkins University School of Medicine.

Supported in part by the Maternal and Child Health Service Project Grant 12 H201 and from the Department of Pediatrics, Johns Hopkins Medical School and Johns Hopkins Hospital, Baltimore Md 21205.

In the first section of this series the need for early recognition and accurate diagnosis of the infant with congenital heart disease was emphasized. The present communication will deal primarily with the medical and surgical management goals of such infants.

Although the mortality rates for certain congenital cardiac lesions remains high, potent drugs and newer surgical techniques have made definite inroads toward early cure in others. Medical management is directed primarily to the control of congestive failure, alleviation of cyanotic spells under certain conditions, and control of arrhythmias. Surgical management may be divided into two categories: palliative and corrective. Palliative procedures are basically designed to either decrease torrential pulmonary blood flow or increase markedly diminished pulmonary blood flow. Corrective surgery obviously is directed toward the basic anatomic defect.

The nine most frequently occurring lesions in early infancy were outlined in the previous section. Review of this group indicates the formidable challenge of management facing the primary physician, cardiologist, surgeon, and, last but far from least, the family.

Hypoplastic Left Heart Syndrome

This devastating lesion is characterized by severely hypoplastic or atretic left ventricle, mitral annulus, and ascending aorta. Infants

with this defect generally present with signs of severe congestive failure and cardiogenic shock in the early newborn period. Cardiac catheterization is not tolerated well by these babies and they tend to show a relentless downhill course of progressive acidemia and hypoxemia. Palliative surgery has been undertaken in some centers; the overall results have been bleak; and, as yet, no hope for eventual correction is in sight. We believe that verification of the diagnosis should always be undertaken by catheter study. The parents can then be informed of the implications of an established diagnosis with certainty.

Coarctation of the Aorta

It is unusual for isolated coarctation of the aorta to "present" in early infancy. This is a diagnosis that usually must be actively sought by careful examination of the blood pressure and pulse wave contours of the upper and lower extremities. However, when combined with one or more additional cardiac lesions, coarctation becomes one of the most frequent defects requiring aggressive medical or surgical management in infancy. As many as 92% of the infants operated for coarctation because of congestive failure may have an associated lesion involving the heart.

Accurate anatomic diagnosis of both the site and extent of the coarcted segment in addition to a thorough search for any other cardiac defects has important bearing on the overall treatment plan. These infants under one month of age should be given the benefit of maximum medical therapy before surgery is contemplated because the operative mortality rates are high and re-stenosis frequent. However, if favorable response is not obtained within a relatively short period, surgical correction should be undertaken without further delay. In addition, attention must be directed toward relief from or palliation

of the associated anomaly (ie, ligation of a PDA or pulmonary artery banding in the presence of large left-to-right shunt).

Rarely, isolated coarctation may present in congestive failure with such severe upper-segment hypertension that surgical intervention should be undertaken to obviate the possibility of cerebrovascular accident.

Great Arteries Transposition

The transposition group can be divided into three subgroups. Although the overall goal is eventual "correction" by surgical placement of an intra-atrial baffle redirecting venous return, the management plan is somewhat different.

First and most common are the transpositions with trivial or no associated shunting. These infants are severely hypoxic and constitute a genuine emergency for diagnosis and palliation.

At catheterization, once the diagnosis is established, balloon atrial septostomy should be attempted in all cases. By and large, this procedure is followed by a prompt rise of arterial oxygen saturation. This improvement, however, may not be sustained. The first week to ten days post septostomy are critical ones and careful monitoring of the arterial blood gases is required. If progressive deterioration in these parameters should supervene, surgical creation of a large atrial communication may be necessary. In addition, signs of congestive failure must be carefully sought and digitalis therapy instituted if and when they appear.

Although perfusion and hypothermia techniques have brought "correction" closer to the neonatal period, successful results in infants under six weeks of age are rare. A transposition of this type may be repaired electively with this technique after about six months of age. Thus a treacherous period of six months remains for these children.

The patient with transposition combined with a large shunt (usually a VSD) tend to present later and with symptoms of congestive failure. Digitalization and diuresis are instituted. Again, after the anatomic diagnosis is established, balloon septostomy is performed. These children are prone to the early development of pulmonary vascular disease. For this reason they require repeat catheterization at about six months of age to evaluate pulmonary vascular resistance. Increasing resistance or uncontrolled congestive failure may force palliation in the form of pulmonary artery banding. The presence of the VSD significantly increases the risk of corrective surgery; therefore, such a procedure is generally deferred until the patient is at least two years of age.

When pulmonary or subpulmonic stenosis complicates either of these first two categories, severe hypoxemia again becomes the primary concern. Balloon septostomy is accomplished as soon as the diagnosis is established. Depending on the degree of obstruction to pulmonary blood flow, only limited improvement in the arterial oxygen saturation can be expected. Under these conditions, continued desaturation is indication for the palliative creation of an aortico-pulmonary shunt. Of the transposition group, these infants require the most complex surgical procedure and have the highest surgical risk. For these children, correction is usually delayed until middle childhood.

Hypoplastic Right Heart Syndrome

As the name implies the right heart apparatus (including the pulmonary valve, right ventricular cavity, and tricuspid valve) is hypoplastic. Early and intense cyanosis dictates emergency diagnostic catheterization. Because survival is virtually dependent on an adequate atrial communication, balloon septostomy should be performed. The establishment of the size of the right ventricle is of critical importance.

In the case of pulmonary atresia with an adequate-size right ventricle (20% of cases), the appropriate surgical approach should be directed at the atretic valve; if the right ventricle is diminutive, surgical attention is directed toward aortico-pulmonary anastomosis (usually ascending aorta to right pulmonary artery). Pulmonary valvulotomy should then follow at about three months of age. There is some evidence to suggest that the relief of the obstruction, thus allowing flow thru the right ventricle may lead to expansion of that cavity, hopefully allowing for eventual total correction.

Tetralogy of Fallot

Features of the tetralogy of Fallot are well known by most practitioners. As indicated in the preceding section, these infants infrequently present in the early neonatal period. Medical and/or surgical intervention may not be required for some months. The therapeutic approach depends to a large extent on an accurate delineation of the anatomic defect at cardiac catheterization. Patients plagued by "cyanotic spells" can be offered alternative routes of treatment depending on location and degree of obstruction to egress of blood over the pulmonary outflow tract.

Those with marked infundibular stenosis, moderate to severe pulmonary valvar stenosis, or atresia are best treated by aortico-pulmonary anastomosis, preferably a Blalock-Taussig shunt, contralateral to the side of aortic descent. Those

with moderate or labile infundibular stenosis may be offered trial therapy with the beta-adrenergic blockade agent, propranolol.

Failure to produce prompt reduction in the frequency and severity of cyanotic spells is indication for surgical intervention. The overall aim is, of course, total correction. Again, the anatomy of the pulmonary outflow apparatus has important bearing on the timing and extent of the procedure. In general, infundibular stenosis with normal pulmonary valve annulus is considered favorable anatomy for early correction, while a small annulus and main pulmonary artery preclude early correction because extensive plastic repair of the outflow tract may be required.

Truncus arteriosus

Of the four forms of this defect, Type I (pulmonary arteries arising from a common branch off the trunk, and Type II (pulmonary arteries having separate but closely related origins from the trunk) comprise 90% of this group. The course is a treacherous one for these unfortunate infants. Even diagnostic study carries enhanced risk. Control of the torrential pulmonary blood flow is mandatory and should be carried out as early as the physiologic status and anatomy allows. Pulmonary artery banding carries high mortality, but if successful has produced dramatic results. Correction involves multiple surgical maneuvers, including the use of a homograft pulmonary artery, but has been accomplished in all four types and therefore an aggressive approach is warranted.

Ventricular Septal Defect

The variety of size and location of the defect(s) together with the influence of pulmonary vascular tone is reflected in their protean manifestations. Generally they may be divided into severe, moderate, and mild categories based on careful clinical and catheterization assessment. The moderate and severe categories require early medical management and eventual surgical correction. Control of congestive failure with digitalis therapy and diuresis usually allows postponement of surgery until the child reaches 10 kg but probably should not be delayed beyond the second year of life. Those infants with the combination of a large defect and low pulmonary vascular resistance allowing massive left-to-right shunting may prove extremely difficult to manage because of recurrent pulmonary complications and failure to thrive. These infants should be considered for early correction using surgical hypothermia.

Patient Ductus Arteriosus

Although surgical closure of a patent ductus

has the lowest risk of mortality at any age of the lesions under consideration, a still further and significant decrease in mortality occurs after about six weeks of life. Therefore, a full and aggressive trial on medical therapy is indicated before subjecting the neonate to operative intervention.

Endocardial Cushion Defects

Embryologically, the endocardial cushions contribute to portions of the atrial septum, ventricular septum, and each of the atrioventricular valves. It can be appreciated that defects in the formation of these cushions may result in a broad spectrum of lesions varying from the ostium primum atrial septal defect to a malformation involving communication between all four chambers and incompetence of both the mitral and tricuspid valves. In addition, many of these patients also have Down's syndrome which has altered the philosophic posture toward the therapy by some.

Our position has been to proceed with complete diagnostic and therapeutic procedures consistent with good medical care and the desires of the family. Success of medical management is dependent on the severity of the lesion. Failure to control congestive failure through digitalization and diuresis may demand operative intervention. Palliative pulmonary artery banding carries increased risk of mortality and may not be of benefit. Corrective surgery is technically demanding but potentially a very rewarding undertaking. In general, we try to forestall corrective surgery until the child reaches approximately 10 kg in weight. Careful observation and selection of patients enhances the likelihood of achieving a favorable result.

Summary

This series was designed to outline the recognition, diagnosis, and major management aspects concerning nine of the most frequent forms of congenital heart disease presenting in infancy. At present, despite considerable progress, the attrition rate remains high. We believe early detection coupled with continuing efforts toward better, less invasive diagnostic techniques, and earlier surgical correction are the only means by which the losses will be reduced. This requires the cooperative efforts of primary physician, cardiologist, and surgeon. We feel obligated to point out that, although not discussed, the facilities and personnel involved in the intensive care of such patients are significant.

Acknowledgment

The authors are indebted to Richard D Rowe MD for his contributions to our appreciation of the neonate with congenital heart disease and to "Neonatal Cardiology" in general.

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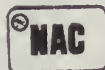
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MEDLINE NEWS

Between March 26 and April 13, Joseph E Jensen, the assistant librarian, attended a MEDLINE training course at the National Library of Medicine. The course consisted of an intensive indoctrination in the capacities of MEDLINE and how to access and use the now nearly two million citations stored in the computer's memory. Mr Jensen returned with a box of notes, manuals, dictionaries, and user guides. He promptly sat down at the library's new NCR terminal, and has hardly gotten away since.

What can MEDLINE do?

1) It can help answer questions. During the annual meeting in April, when 32 searches were completed, a physician asked us about skin rash as a reaction to either acetaminophen or propoxyphene. The terminal promptly retrieved an article from *JAMA* entitled "Acetaminophen sensitivity and fixed dermatitis."

2) It can provide bibliographies on medical subjects. Recent requests include: *Use of procaine, xylocaine or lidocaine in treating vascular diseases*, *Use of the irrigation smear versus colposcopy in the diagnosis of cervical diseases*, *Urolithiasis as a complication of ileostomy or colectomy*. Not all requests are fruitful. A request for "the ethics of allowing patients to use bank credit cards to pay their medical bills" had no return. This does not mean that there is nothing written on the subject. Such failures could be due to the limitations in the system itself, or to the inexperience of the analyst doing the search.

3) Through MEDLINE, the terminal can provide a monthly update of new literature on a medically related subject. If a physician wishes, we can send him a monthly bibliography of the latest articles on a subject. Because of the popularity of acupuncture, the library is currently running a monthly bibliography of the latest articles on Oriental medicine, acupuncture, and moxibustion.

Other MEDLINE capabilities are in preparation at the National Library of Medicine. We will inform you of them as they develop. In the meantime, if you believe MEDLINE can help you, or have any questions about the service, call the library at 539-0872 or, better, drop in and see us at 1211 Cathedral St.

Request forms are available and will be mailed to you for your convenience as well as uniformity. See the accompanying sample.

Medical Library Association, Kansas City, May 27-June 1

During a conference filled with continuing education courses and "continuous" meetings the week was extremely full. Many conflicts occurred since one body can fit into only one place at the time. For instance, the Medical Societies Luncheon, a must for us, was scheduled at the time of a Hospital Library Group luncheon which featured Dr Loren F Taylor speaking on medical malpractice.

For once the exhibit area was open from 9:30 AM to 6:00 PM on Monday thus enabling those not participating in continuing education courses to view the exhibits. Heretofore, since exhibits were not ready then and schedules crowded, very little time was allowed for visiting the displays or discussing problems with exhibitors.

Two MEDLINE courses were offered — one specifically for administrators with MEDLINE centers in their libraries. Other courses were scheduled before and after the regular conference sessions, enabling applicants to arrange classes to meet their own requirements, and, in some cases, to enroll for more than one course.

Altogether, it proved to be among the best planned and interesting conferences of the Association.

The 1974 conference will meet in San Antonio Texas June 2-6.

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Subject of request. (Be very specific. Define terms having special meanings. State points not to be included. State English only, or specify languages, or no restrictions.)

Please list one or two articles that you know to be relevant to your request. (If you are expecting an extensive bibliography)

Purpose of your request	Do you want:	Approximately how many articles do you expect to be retrieved?
Research <input type="checkbox"/>	a few very relevant articles. <input type="checkbox"/>	1 — 5 <input type="checkbox"/> 16 — 30 <input type="checkbox"/>
Clinical <input type="checkbox"/>	a comprehensive search possibly containing peripheral articles. <input type="checkbox"/>	6 — 15 <input type="checkbox"/> 31 + <input type="checkbox"/>
Allied Health <input type="checkbox"/>		
Student <input type="checkbox"/>		
Other <input type="checkbox"/>		

Should we send you a bibliography ☐, a bibliography along with copies of a few relevant articles ☐, or copies (up to 50 pages) of articles retrieved in this search ☐.

NEW ACCESSIONS — BOOKS (Arranged by Subjects)

ALLERGY

- WD Patterson, Roy, 1926-
300 **Allergic diseases: diagnosis and management.**
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AUTONOMIC NERVOUS SYSTEM

- WL Steiner, George
600 **Immunosympathectomy.** Amsterdam, New
.S8 York, Elsevier Pub Co, 1972

BIOLOGY

- QH Hamilton, Michael Pollock, 1927-
431 **The new genetics and the future of man.**
.N5 Grand Rapids, Eerdmans, 1972.

CENTRAL NERVOUS SYSTEM

- WL Paine, Richmond Shepard, 1920-
340 **Dyslexia and reading disabilities; papers.** New
.P2 York, MSS Information Corp, 1972.

EMBRYOLOGY

- QS Bergsma, Daniel
675 **Birth defects; atlas and compendium.** Balti-
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ENDOCRINE SYSTEM

- WK Bloom, Arnold
850 **Diabetes explained.** Baltimore, University Park
.B6 Press, 1971.

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- WW Becker, Stanley C
143 **Clinical gonioscopy; a text and stereoscopic**
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WW Fox, Sidney Albert, 1898-
168 **Lid surgery—current concepts.** New York,
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- W Ennis, Bruce J, 1941-
740 **Prisoners of psychiatry; mental patients, psy-**
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- WI Reuter, Stewart R
141 **Gastrointestinal angiography.** Philadelphia,
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- WH Gold, E R
425 **ABO haemolytic disease of the newborn.**
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- W Katz, Jay, 1922-
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W Sinclair, David Cecil
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- W Cragan, John F
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- WL De la Torre, J C
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17 **Fine morphology of mammalian fertilization**.
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- WS **The Genetic, metabolic and developmental aspects of mental retardation**. Edited by
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- QT Brown, B J, 1933-
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- WM Chambers, Carl D
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270 **The teenager in a drugged society**; a symptom of crisis. New York, Richards Rosen
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- HQ Cox, Frank D
734 **American marriage**: a changing scene? Du-
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HQ Resnik, H L P
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- WF Symposium on Pulmonary Emphysema and
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- WO Najarian, John S
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WO University of Iowa, Dept. of Surgery.
140 **Manual of surgical therapeutics**, by Departments of Surgery, University of Iowa, and University of Illinois, 2d ed. Boston, Little, Brown, 1972.
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- WJ Scott, Russell, 1925-
100 **Current controversies in urologic management**.
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Educational Seminar

The Baltimore Chapter hosted the Annual Educational Seminar for AAMA for the State of Maryland, held at the Cromwell Bridge Holiday Inn in Towson, Sunday, June 3.

Those taking the mini-test for AAMA certification arrived at 8:30 AM, well ahead of the 10:00 AM general registration.

The assembly was welcomed by Mrs Lila Adams, President of the Baltimore Chapter.

The current interest in acupuncture was heightened by a cassette tape presentation entitled "Acupuncture and Body Energy."

This was followed by the drawing for door prizes and luncheon.

Highlight of the day's activities was the panel that occupied the program for the afternoon. It was a discussion on "The Battered Child Syndrome" and was moderated by Ronald N Kornblum MD, Deputy Chief Medical Examiner for Maryland.

Other panelists included Charles E Bernstein, Assistant US Attorney; and James Anderson, District Supervisor, Protective Services — Special Services, Department of Special Services.

Lab Orientation

The Medical Examiner's Office was the scene (March 27 and April 3) of a mini Laboratory Orientation Course.

It was conducted by Mrs Peggy Bury. She completed her certification from St Joseph Hospital in Towson in 1961, attended the University of Maryland and Catonsville Community College, and was certified by AAMA (clinical) in 1969.

These classes should be helpful to all attendees, especially those assistants who are preparing to take the certification examination later.

Various urine specimens were microscopically viewed and explained. All the tests for a complete urinalysis were explored in detail.

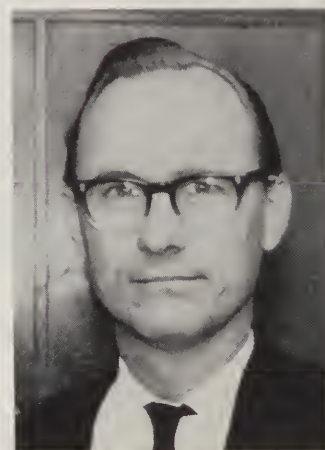
Hematology was also covered, including the latest procedures for the numerous tests presently used for routine and specialized studies.

April Meeting

Elijah Saunders MD, Chief of Cardiology, Provident Hospital, Baltimore; Director, Intensive Coronary Care Unit, Provident; Associate Cardiologist, Maryland General Hospital; and Instructor in Medicine and Cardiology, University of Maryland School of Medicine, was the guest speaker at the April 10 meeting.

The meeting was held in the Medical Examiner's office.

Dr Saunders' topic was "Hypertension — A Community Problem." He noted that hypertension is by far the most common disease treated in the doctor's office.



Dr Kornblum


Dr Saunders said that one out of every seven persons has hypertension and that it is from two to three times more prevalent in the black population than in whites, although whites suffer more myocardial infarctions.

He reported that the VA had completed a study in 1967 which showed that of all cases treated with 95 diastolic pressure and over only 18% had major complications compared to 55% in untreated cases, thereby proving conclusively that hypertensive cases should be treated.

Dr Saunders felt that the reason most people do not seek help for hypertension is that there are no evident symptoms. People do not solicit medical treatment unless they feel ill. A patient objects to this feeling and to the cost of return visits when he has no symptoms.

Dr Saunders concluded that, once a hypertensive, the patient should be treated and followed continuously, and thereby controlled.

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n; acute complications of diabetes mellitus
tabolic acidosis, coma, infection, gangrene);
ng or immediately after surgery where insulin
dispensable; severe hepatic disease; renal dis-
e with uremia; cardiovascular collapse (shock);
r disease states associated with hypoxemia.
arnings: Use during pregnancy is to be avoided.
cautions: 1. *Starvation Ketosis:* This must be
erentiated from "insulin lack" ketosis and is
racterized by ketonuria which, in spite of rel-

atively normal blood and urine sugar, may result
from excessive phenformin therapy, excessive in-
sulin reduction, or insufficient carbohydrate intake.
Adjust insulin dosage, lower phenformin dosage,
or supply carbohydrates to alleviate this state. Do
not give insulin without first checking blood and
urine sugar.

2. *Lactic Acidosis:* This drug is not recommended
in the presence of azotemia or in any clinical situ-
ation that predisposes to sustained hypotension
that could lead to lactic acidosis. To differentiate
lactic acidosis from ketoacidosis, periodic deter-
minations of ketones in the blood and urine should
be made in diabetics previously stabilized on phen-
formin, or phenformin and insulin, who have be-
come unstable. If electrolyte imbalance is sus-
pected, periodic determinations should also be
made of electrolytes, pH, and the lactate-pyruvate
ratio. The drug should be withdrawn and insulin,
when required, and other corrective measures
instituted immediately upon the appearance of any
metabolic acidosis.

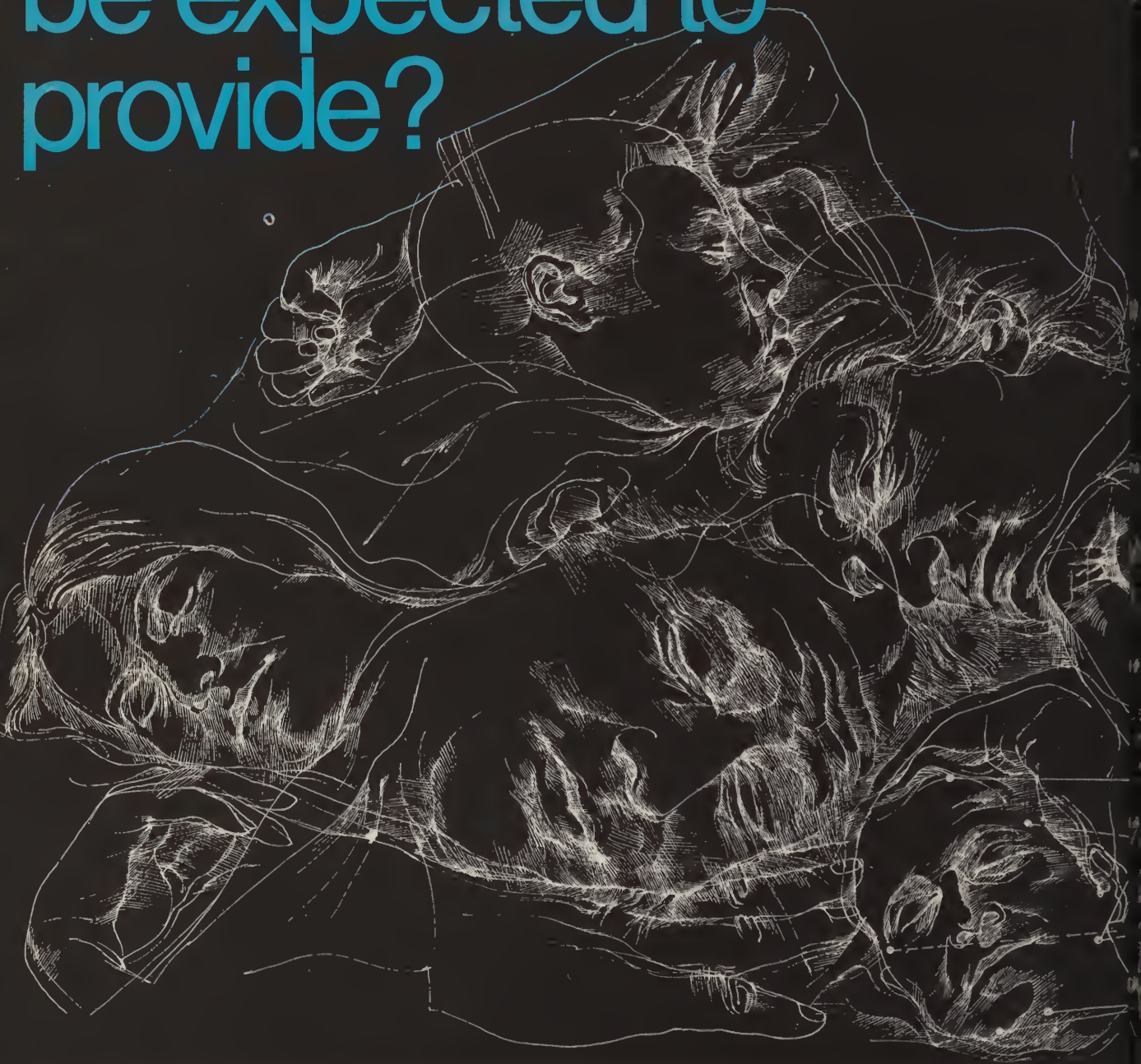
3. *Hypoglycemia:* Although hypoglycemic re-
actions are rare when phenformin is used alone,
every precaution should be observed during the
dosage adjustment period particularly when insulin
or a sulfonylurea has been given in combination
with phenformin.

Adverse Reactions: Principally gastrointestinal;
unpleasant metallic taste, continuing to anorexia,
nausea and, less frequently, vomiting and diarrhea.
Reduce dosage at first sign of these symptoms. In
case of vomiting, the drug should be immediately
withdrawn. Although rare, urticaria has been re-
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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or

recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years

of age. Though physical and psychological dependence have not been reported at recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, initial dosage should be limited to 15 mg to preclude oversedation, dizziness or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with

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Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

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Chronic tolerance studies have confirmed the relative safety of Dalmane; no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. Dalmane is generally well tolerated and morning "hang-over" is relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in elderly and debilitated patients. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

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(flurazepam HCl)

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(15 mg may suffice in some patients).

One 15-mg capsule h.s.—initial dosage for elderly or debilitated patients.

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depression or suicidal tendencies. periodic blood counts and liver and kidney function tests are advised during prolonged therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia, falling have occurred, particularly in elderly or debilitated patients. Severe drowsiness, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech,

confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients.

Elderly or debilitated patients: 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

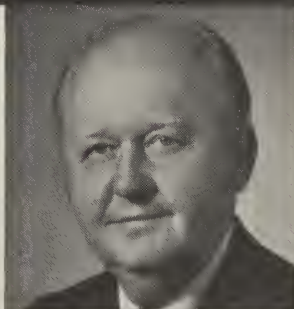
Dispenser of Medicine

Clifton J. Latiolais
President
American
Pharmaceutical
Association



Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical
Manufacturers
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MDs have given the impression they are not particularly concerned with the increase in cost of health care to the patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 2

ould be an obligation of medical practice...

"Medical societies ought to continue continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patient's interest, question the practices of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care. For 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary.

In short, what the American Pharmaceutical Association advo-

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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Baltimore City Medical Society

Drug Use and Abuse

DONALD M PACHUTA MD
Editor

PSYCHOSOCIAL ASPECTS OF DRUG ABUSE

Part 1: Etiological Considerations

LEON WURMSER MD

Dr Wurmser is Associate Professor of Psychiatry, University of Maryland School of Medicine; also Clinical Director, Drug Abuse Treatment Program, University of Maryland Hospital, Baltimore.

What I am going to present is philosophical in tone, at times Byzantine in style. And yet, I feel I should not approach these questions with the usual pragmatic, simplistic, cookbook orientation. This one may find in the flood of publications about drug abuse. I shall present what I consider relevancies that have been little considered up to now.

Psychosocial Aspects and the Question of Causation

We are by now familiar with the slogan, "drug abuse is just a symptom." What is meant by it has been rarely explicated, however. Let us then unravel the texture of causation from a particular corner.

Edmund, Gloucester's depraved bastard in "King Lear," this protagonist of the absolutely antithetical, states: "This is the excellent foppery of the world, that when we are sick in fortune — often the surfeit of our behavior — we make guilty of our disasters the sun, the moon, and the stars, as if we were villains by necessity, fools by heavenly compulsion; knaves, thieves, and traitors by spherical predominance; drunkards, liars, and adulterers by an enforced obedience of planetary influence . . ."¹

Are we any more scientific today if we ascribe our deviations, our sickness in fortune, to other forms of necessity and compulsion, to the constellations of social and inner causes? Many would derisively deny this and indeed relegate the social sciences into a line with astrology.^{2,3}

And yet, I believe most of us who deal with

this problem (physicians, nurses, judges, social workers, and others) have been struck by this impression of "an enforced obedience" by this picture of "fools by compulsion" when we dealt at least with one type of people involved with illicit drugs. True, we usually do not have that feeling with those who dabble in drugs, experimenters, occasional or recreational users. Nor do we probably have that impression with the grand entrepreneurs on the black market, the large scale profiteers. But the users we see most frequently as patients, defendants, or prisoners belong to this category of compulsive users of drugs. We also have learned to our chagrin that for them deterrence, persuasion, and punishment are of little avail.

May it then not be that it is just the common neglect and our own conviction of this crucial fact of inner compulsion which has filled most of us at times with a sense of hopelessness and helplessness about this problem: "once an addict, always an addict"? This frustration has led to ever more vindictive reactions (like exorbitant sentences), or to fanatical, one-sided postulates of a final solution (like most massive intercepting operations or some treatment ideologies), or to an escape into naively optimistic hopes set on education. The common approach to this question is that of placing the problem in the drugs, not in the personalities involved in drug use.

What this paper purports to do is to shift the focus away from a hated group of chemical substances to a particular group of compulsive types of behavior and thus to the problem of persons enslaved to various external objects, not enslaved by them. I know such a change in focus is hardly popular, yet I consider it inescapable.

If we study, however, this problem of compulsiveness, we recognize that compulsive drug use

is embedded in a context of other compulsive activities and encompassing problems and conflicts which I will try to explain more carefully.

When we explore the life history of compulsive drug users, we find a rather typical sequence of events: a severely disrupted family, either no father, or constant fights; most of the time an atmosphere of deception and manipulation; early symptoms in the growing child: of rage, running away, often of anxiety and loneliness or of vague tension, boredom, lack of inner and outer structure; quite often early though petty criminality: shoplifting, vandalism, or stealing a car. Later, in early adolescence, abuse of alcohol, a frantic plunging into premature and promiscuous sexuality and more antisocial acts. Still later, the shopping around for, the trying out of, various drugs, until they hit, usually in the middle or late adolescence, on the drug of choice. We cannot escape the conclusion that compulsive drug use is the last of the "flowers of evil," (to borrow from Baudelaire's "Fleurs du Mal"), the last of the manifest symptoms in a long series, on a plant reaching with its roots deep into the soil of family pathology and, through it, into the ground of broader, social and cultural problems.

What are the underlying causes? Let us work our way backward from the symptom of compulsive drug use and, despite the current clamor for easy answers, try to discern the various strands in this complex etiological texture and assign them various weights as to specificity.⁴⁻⁶

1) First we encounter the *physical dependency* on the drug which enforces the continuation of its use — the wish to avoid the physiological withdrawal symptoms. This is a *noisy* factor, but in my experience almost *insignificant* as a factor of enduring motivation. The focus on *drugs themselves*, on physical dependency, blinds us against the massive problems behind and does not allow us to understand such common phenomena as the easy switch during times of scarcity; eg, of heroin to pharmacologically entirely different drugs, like barbiturates and other sedatives.

2) Behind it we find (historically) the first encounter with the drug — the peer group pressure, the offer by a friend (alias minor pusher), the curiosity. When we notice that only a small number of those exposed to these first encounters actually go on to become compulsive drug users we have to assign to this factor a low causative specificity. This *adventitious entrance* of the drug functions like a catalyst; it is a trigger event, a precipitating cause.

3) On the next deeper level we meet with what I believe to be one of the two most specific elements in this entire hierarchy of causes, a fac-

tor we might call the *addictive search*: an intense, desperate attempt to seek relief from inner pressure and tension in something on the outside. The addictive search may be directed to alcohol, gambling, food, television, racing, or sexuality. It is always a frantic running away from a nagging inner sense of distress which we will explore shortly.

The other quite specific factor, combining with the one just described, is often an *external crisis*, exacerbating the inner tension, usually a crisis of trust and meaning. Of course, all adolescents and most adults pass in life through such crises. In our patients, however, these external crises may be more massive; eg, a severe family conflict, or they are more devastating because they mobilize very intense feelings inherent in what I just described as the addictive search.

4) This brings us to the next, the fourth level in our backward journey, namely the causes underneath this search. Here we have to dwell for a while. The most important aspect of what I hinted at before as the nagging inner sense of distress are various *overwhelming feelings* of great intensity; the search is on for external help to cope with this pressing Affect. In other words, the external object serves as a crutch for a specific internal defect.

I consider all compulsive drug use an *attempt at self-treatment*. More specifically, the importance of the drug Affect in the inner life of these patients can perhaps be best explained as an *artificial or surrogate defense* against overwhelming Affects, when the ordinary barriers are lacking. In the past, the satisfying, *wish-fulfilling* aspects of drug Affects have been emphasized. To put this in a catch phrase: drug use was mainly seen as an expensive search for cheap pleasure. This certainly holds true for the popular and unreflective concept of why people take drugs; earlier analytic theoreticians also followed this lead in that they saw in drug use, as in other symptoms, only the satisfaction of *unconscious* wishes. I do not deny the importance of the wish-fulfilling aspects, but I believe we might be more specific about the obverse side of the same coin, namely about drug use as a defense.

Certainly, the view that drug use is an *escape* has also been popularly held, but again mainly in regard to intolerable external situations. To my knowledge, the concept of the need for drugs as a specific defense against intolerable internal factors and, more specifically, Affects, has been seldom described. And here we now begin to recognize some specificity between drug chosen and Affect combated. These correlations which I am going to outline are very tentative and

quite incomplete, but I think they present a promising beginning.

Narcotics, as well as barbiturates, appear to help specifically against overwhelming feelings of rage, shame, and loneliness (or hurt by separation). Every event triggering these three feelings serves as an external crisis, prompting the search for relief with the help of one of these drugs. In turn, whenever we force or help a patient to do without his sedative of choice, these feelings burst through, at times in murderous violence, at others as suicidal despair or aimless tension and rage. Occasionally, what comes forth when the narcotic is stopped is a floridly psychotic rage. This breakthrough of these Affects is not an inexorable event. If there is a lot of external support and help, it is sometimes possible for the former patient to cope with these feelings and underlying conflicts.

If we move on to a second group, the stimulants (amphetamines and cocaine), the Affects combated are somewhat different, namely massive depression and self-degradation, or a vague though intense sense of unworth, incompetence, inferiority, and inadequacy. I repeatedly saw patients who had been off amphetamines for many months move in and out of very severe depressions which reminded them of the states of despair antedating their drug use. Some suffered from intense self-directed aggression; some from suicidal rage and despair; others from lethargy and self-degradation. Abuse of these drugs can, at least in some patients, be called an artificial normalizing, or even a *manic defense* against the *underlying Affect of depression*.

In a last group, the compulsive use of psychedelic drugs, eg, LSD or hashish, the drug effect fills the inner void, defends against intense feelings of emptiness, meaninglessness, and boredom, an effect actually very akin to the compulsive watching of TV and movies.

Thus, the choice of a specific drug as drug of preference — often found after long shopping around — is specifically related to the *Affects* engendered by the internal conflicts; when the inner structures fail as defenses, the pharmacogenic effect has to serve this purpose of inner barrier. *If we suppress this attempt at self-treatment without massive support to the ego of the patient, we force him into often more serious forms of decompensation: violent (even homicidal) rage in the narcotic addict, severe suicidal depression in the amphetamine user, a careless apathetic drifting in the psychedelics user.*

There are other factors underlying the addictive search, combining with this element of the

artificial defense against overwhelming Affects.

An important one is a defect in the formation of ideals and values. The Affects just described usually emerge during or following a crisis where such central values, ideals, and myths have been shattered or when the need for such an ideal has become particularly prominent, its absence, or unreliability, particularly painful. And here the family pathology and, on a wider arena, the social and cultural conflicts enter. *Parents who did not provide a minimum of consistency and reliability, especially during the child's crises of growing up, are not usable as inner beacons, but solely as targets of rebellious rage and disdain.* The "high," the relief and pleasure sought with help of the drug, even the hustling, is a surrogate ideal, a *substitute value*, a *chemical mythology*, which normally would be supplied by the internal sense of meaning, goal directedness and valuation.

Another internal factor predisposing for the addictive search is a partial degradation or rudimentary development of the *symbolic life* and, with that, of the fantasy life. As we noticed before, this inability to symbolize pertains particularly to the inner life, to the emotions, *the inability of most of these patients to articulate feelings.* Many, if not all, relevant Affects are translated instead into somatic complaints; eg, about "craving" and physical discomfort, or into social accusations — "it's all society's fault." They remain preverbal as Affects. It is just this lacuna which makes psychotherapy so particularly difficult and frustrating. (After all words are the major tool of psychotherapy).

Tentatively, we might dub this defect "*hypo-symbolization.*" (I would speculate that television, with its nonsymbolic overload, fosters, though not causes, this disorder; and that its origin again points back to deficiencies in the early environment). The drug is utilized, not to substitute for the lacking symbolization proper, but to remove that discomfort which is now perceived not as Affect, but as an untoward somatic or outer reality; it alters body image and world image into a less unpleasant or more meaningful one. In other words, it works on the projection.

Other internal predispositions entering into the causation of compulsive drug use include an often intense need for passive *dependency*; very archaic forms of self-condemnation with radical fears of *global humiliation* and retaliation instead of a solidly internal conscience; and, finally, the search for what we call *narcissistic gratification* — the fantasy of being grand, invincible,

omnipotent, and provided with limitless warmth and love. I do not discuss the archaic dependency and the self-punitive, self-destructive factors in this illness; they are well-known. Like Kohut, I did not find them always as relevant as usually described.

5) If we now move backward in history and deeper down in the psychical structure of the patients, we encounter, in vague contours, archaic conflicts of a narcissistic nature, *conflicts about limitations* of the self, of others, and the world. The wish is: "I don't want to have limitations, nor should the power of others to gratify me be limited." Every "No," every limitation, is an intolerable disillusionment and insult, and leads to despair or rage, to shame or emptiness. Such narcissistic conflicts are of course, fairly unspecific; many other severe emotional disturbances are based on such conflicts.

6) These conflicts are embedded in *family* deficiencies and conflicts engendering such massive narcissistic problems and defects in ideal formation and handling of overwhelming affects.

What we described as Levels 4, 5, and 6, namely the factors directly underlying the addictive search, especially the need for affect defense, the archaic narcissistic conflicts, and pervasive family problems may be grouped together as *predisposition* to compulsive drug use.

It appears very likely now that it is the convergence, at least of some, if not all, of these elements: the massive *defect of affect defense*, the *defect in value formation*, the *hyposymbolization*, the desperate search for an *object substitute*, the intensely *self-destructive* qualities and the search for regressive gratification together with the *intensity of narcissistic conflicts* as mobilized in an acute crisis — which forms the specifically causative constellation for the addictive illness in general, for compulsive drug use in particular. And yet of all those, the first one, the factor of Affect defense, appears to me the most specific one.

7) You notice that up to now I have neglected talking about what everyone uses as explanation: social injustice, disappointment about modern life, etc. In my experience, such *sociocultural* factors are more smoke screen than origin. I concede that they serve as broad background, as a foil, as contributing factors. But only a fraction of those exposed to them become compulsive drug users, and in turn many not exposed to them are addicts. We may classify them as *concurrent* causes, nonspecific auxiliary factors, working through families and peer groups, not directly. Important contributing causes are the following, to select just a few:

A first group pertains to the effects of poverty

and discrimination. The *lack of structure*, discipline, tradition, cohesion; and the amount of violence, overcrowding and with that of *overstimulation* in the slums; the role of drug traffic as an important stabilizer in the ghetto economy; the emergence of the successful pusher as an ideal in a society of degradation and self-contempt; the value of hustling as an exciting activity if skills and jobs are lacking. Nor should we forget about the latent, though massive, rage in this atmosphere of psychological as well as economic deprivation.

A second group encompasses factors in middle- and upper-class society: a profound doubt in the values of materialistic society, a mystical search for so-called spiritual values, the flight from Western activism and competitiveness into Oriental contemplation and passivity; and, quite importantly, a protest against hypocrisy and manipulation, double standards and injustice, perceived in the ruling institutions.

I would not like to omit, however, several often forgotten aspects which may be more relevant than these commonly proclaimed ones. One is the formative role of television throughout childhood. I often wondered whether the emphasis on narcissistic aspects, deceit, and violence, and particularly the enforcement of passive dependency, in form of the unlimited gaping and receptive staring and with that the stunting of symbolic activities and of active fantasy formation,^{7,8} may not contribute to some of the more specific problems mentioned before. "Yet any sensitive observer of the American scene recognizes that modern mass advertising at its heart represents a kind of institutionalization of deception and misrepresentation." Schur calls it "a philosophy of contempt for and manipulation of individuals," inducing "a kind of narcotization to fraud."⁹

Another aspect is the removal of sexual activity from an area of high tension, secret longing, and overt titillation, from a field of anxiety and revolt, to an area of routine, of boredom and mechanical performance. The deeper wishes inherent in sexuality (of merger, belonging and sharing, of idealization and renunciation) and with that the whole yearning of young people are thus torn from the moorings. There has been little consideration of the impact of a shallow, technically and pragmatically oriented, but vastly protracted education. Schooling, devoid of most tradition and humanistic values and carried by teachers vastly underpaid, undereducated and held low in esteem, cannot provide those values and ideals which could give most of us a badly needed structure in times of crisis—whether

in the developmental crisis of adolescence or the historical crisis of demythization and devaluation in which we are stuck.⁹⁻¹¹

Finally, in this group, we may consider the importance and impact of a general spoiling, of the wilting of authority and limitations, and with that of challenge, expectation and aspiration. The shallow hue and cry about the permissiveness of our society may have a shred of reasonableness if we look at this last point.

As said before: All these are merely contributing factors, pointing lastly to value philosophical conflicts.

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NIH Study of Interstitial Pulmonary Fibrosis

The cooperation of physicians is requested in the referral of patients with interstitial pulmonary fibrosis for studies being conducted jointly by the National Institute of Arthritis, Metabolism, and Digestive Disease's Arthritis and Rheumatism Branch and the National Heart and Lung Institute's Pulmonary Branch, at the Clinical Center, National Institutes of Health, Bethesda Md.

Needed are patients 40 years of age or older.

Of particular interest are the etiology, mechanism, and treatment of interstitial pulmonary fibrosis secondary to scleroderma or arthritis (rheumatoid or idiopathic).

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write

Dr Harold H Newball,
Clinical Center, Room 6-D-05,
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phone (301) 496-1597

SS Hope Uses South Baltimore Facilities

Thanks to a letter received from Brazil, it has been learned that laboratory work for the hospital ship, SS Hope, was performed at South Baltimore General Hospital while the ship was drydocked in Baltimore.

Watson Kime MD, Director of Laboratories at the hospital, has disclosed the contents of a letter received from Martha Hopkins, Chief Medical Technologist for Hope. Said Mrs Hopkins.

"Thanks to you and your staff for all the laboratory work performed for us while the SS Hope

was in drydock.

"I believe I explained that we found it necessary to do physicals on some crew members as one way or another they were able to 'pass' their physicals at the Public Health Service. We found a great many of them unfit for duty and thus saved ourselves a great many problems during our stay in Brazil.

"It was just not possible to set up the chemistry lab at that time due to lack of facilities and personnel. Your assistance was a worthy contribution to our efforts."

North Charles Hospital Gets \$10,000 Grant

The North Charles General Hospital, Baltimore, has been awarded a \$10,000 Max Baer Heart Fund Grant from the Fraternal Order of Eagles of Baltimore Aerie #59.

Bernard Tabatznik MD, Chief of Cardiology, accepted the grant for the hospital in presentation ceremonies participated in recently by hospital and lodge officials.

Dr Tabatznik noted that the money will be used in a special research project in the hospital's expanding cardiology department.



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Secretary

Maryland State department of health and mental hygiene

MARYLAND'S PARTNERSHIP APPROACH TO COMPREHENSIVE HEALTH PLANNING

EUGENE H GUTHRIE MD
FREDERICK NEVINS PhD

Dr Guthrie is Executive Director of the Maryland Comprehensive Health Planning Agency and served for 20 years in the US Public Health Service, where he was ultimately appointed Associate Surgeon General.

Dr Nevins is Associate Executive Director of the MCHPA and also served in the US Public Health Service for 20 years, directing Program Planning and Evaluation for the Bureau of Disease Prevention and Environmental Health.

In 1968, the Maryland General Assembly gave the responsibility for the development of a coordinated health planning process and for the supervision of the State's health planning functions to the Maryland Comprehensive Health Planning Agency (MCHPA) by enacting Section 59C of Article 41 of the laws of Maryland.

Maryland acted, as did the 49 other states, in response to Public Law 89-749 enacted by the Congress in late 1966. The Congress declared in this Act that one of our principal national goals is to promote and assure the highest level of health attainable for every person and that to reach this goal there must be an effective "partnership for health." Close intergovernmental collaboration, private and voluntary efforts, and participation of individuals and organizations are essential ingredients of this partnership. Indeed, all available health resources—national, state and local—must be marshaled to assure comprehensive health services of high quality for every person.

The Partnership for Health program introduced the concept of comprehensive health planning as the mechanism through which the planning activities of all these health-related elements can be linked together. This is no easy task. The health industry, unlike a large corporation or the Department of Defense, is not a mono-

lithic structure which has an executive at the top of the pyramid to whom the organization responds.

Rather, it is a vast nonsystem of private practicing physicians and dentists, voluntary hospitals and other facilities with their own boards; professional and voluntary organizations; insurers like Blue Cross and Blue Shield, etc—all working side by side with local, state and federal health resources. It is the task of Comprehensive Health Planning to establish an orderly planning process within this vast uncoordinated health enterprise.

Further complicating the picture is the fact that health care sources in this country have not been accustomed to operating in a planned atmosphere. Hospitals, clinics, laboratories, individual professional practitioners (eg, physicians, dentists, optometrists, podiatrists, physical therapists), over the years have traditionally been independent entrepreneurs rendering their services largely on an acute illness episodic and person-to-person basis.

Some planning activities have occurred off and on during the years in certain specific fields such as mental health, mental retardation, and emergency care. Also there have been some programs of collective sponsorship of these services into group practice and prepaid health care plans. But, for the most part, these efforts have been fragmented or extremely localized.

To believe that in the early 1970s an organization could accomplish the goals and objectives of comprehensive health planning to include all of the elements in the health-care field and put in practice all the theories of planning would be miraculous to say the least.

The gaps in planning cannot be bridged solely by issuing official edicts that they be overcome or by unilaterally producing sweeping master plans. Achieving comprehensive health planning must, of necessity, be done in increments of activity and time while simultaneously preparing an atmosphere of acceptance of the concept. Quantum leaps in the face of these problems, though desirable, are impossible and impractical in the real world in which we live.

In its operation, the MCHPA is involved in solving problems of health services, facilities and manpower—both personal and environmental, and in finding how these health issues relate to socioeconomic conditions, housing, transportation, education, etc. In fact, the key to successful comprehensive health planning may lie in the linkages developed between and among these various elements; how else can their individual planning and programs be related to form a coordinated health plan for the State? In such a plan, providers and consumers of health services would reach agreement on health needs; goals and priorities; resources and measures required to achieve these goals; and the courses of action necessary to achieve implementation.

When the MCHPA was first staffed and began to operate in late 1968, it set out to build a solid foundation for its future planning activity. The Agency set several objectives to:

- a) Develop statewide health planning capability
- b) Find out who was doing health planning
- c) Determine the quantity and quality of existing health planning data and information
- d) Establish a strong Advisory Council with emphasis on consumer participation

Areawide Relationships

As a first order priority under objective "a," recognizing that comprehensive health planning is dependent upon a strong local planning capability, the MCHPA has worked hard to establish and strengthen areawide health planning agencies throughout the entire State. These areawide agencies are counterparts to the MCHPA, each serving a part of the State large enough to develop an areawide approach to the solution of health problems. To date, areawide agencies have been established covering Metropolitan Baltimore, Western Maryland, the Eastern Shore, Southern Maryland, Frederick County, and Prince George's County (interim). Montgomery County, which is not yet represented by an areawide agency, is expected to participate shortly. A listing of the areawide agencies in Maryland is shown in Table 1.

**Table 1: Areawide Agencies & Counties Represented
Regional Planning Council**

Anne Arundel	Carroll
Baltimore City	Harford
Baltimore	Howard
Health Planning Council of the Eastern Shore Inc	
Caroline	Somerset
Cecil	Talbot
Dorchester	Wicomico
Kent	Worcester
Queen Anne's	

Health Planning Council of Appalachia Maryland Inc

Allegany
Garrett
Washington

Tri-County Council for Southern Maryland

Calvert
Charles
St Mary's

Frederick County Planning Commission

Frederick

Health Planning Advisory Committee of Prince George's County

Prince George's

Maryland was the first state in the nation to appropriate and grant funds to support and develop areawide planning with \$200,000 available in matching grants for distribution to areawide agencies for FY1973. Some of these areawide agencies receive additional federal funding under the provisions of Section 314(b) of the Partnership for Health Act. Memoranda of agreement are signed annually between the State and areawides in order to ensure quality of performance, program and financial reporting, and to delineate program responsibilities. Under these agreements the areawides perform specific tasks necessary to the development of the areawide comprehensive health plan including data collection, analysis and evaluation. Since it is these areawide agencies that will plan and coordinate local programs for improving the delivery of quality health care services in their communities, it is important that they have State recognition and designation of responsibility. The MCHPA provides technical assistance and maintains surveillance over their expenditure of State and federal money.

In addition to their primary function of developing areawide health plans, these agencies also serve as the agent of the State in the review of health facilities proposals under the Certification of Conformance program. This is a new statewide activity, similar to ones developing in many other states, which requires new and expanding hospitals and nursing homes to adequately justify their facilities and services based on needs of the community and conformance to area and State plans.

Under this pioneer Maryland legislation, (Article 43, Section 559 (a-1), Annotated Code of Maryland, Chapter 222, 1968 Laws of Maryland) no hospital or related institution may be established or modified unless it conforms to an area-wide comprehensive health plan. Areawide agencies conduct an independent review of each project and submit their judgment to the MCHPA for final decision. Again, this program points up the State linkage concept, depending upon a strong and capable local partner who acts as the agent of the State.

Also significant in cementing a close working relationship are the regular monthly meetings held by the State Agency together with all the areawide agencies at which program developments and problems are discussed. Typical discussion topics include: a) scheduling joint site visits to State institutions for capital budget review, b) developing positions on pending legislation, c) developing uniform procedures and forms for health data collection, and d) developing statewide projects. In addition, periodic working sessions are held by State and areawide staff, sometimes with Advisory Council members attending, to develop particular programs for that area and to review overall program plans.

Federal Relationships

Similarly, the partnership for health concept is dependent upon a strong federal linkage. This has been exemplified by the financial grant assistance from HEW to the MCHPA amounting to over \$100,000 annually and by the heavy dependence of HEW upon the grant review and comment function of the State and areawide health planning agencies before awarding program and project grant funds. An important feature of the Partnership for Health Act gives the State greater flexibility in supporting comprehensive health services by allowing it to channel grant funds into programs for which it determines that there is greatest need, rather than by federal decision on a categorical basis.

Close liaison is maintained with the HEW Regional Office in Philadelphia which keeps the MCHPA informed of latest national program developments, legislation, and policies. It is noteworthy that in the past year, the Regional Office has revised its grant review procedures to place greater responsibility on the MCHPA before grant support is given. Not only is this the case with the long-standing formula grants for State health, mental hygiene and Hill-Burton hospital construction programs, but most importantly in the newly developing areas, such as Health Maintenance Organizations (HMO) and Developmental Disabilities.

Other State Agency Relationships

Beyond the vertical interaction between federal, State and areawide levels on comprehensive health planning, there is noteworthy coordination horizontally—among State agencies themselves. This is particularly demonstrated in health planning as it relates MCHPA with almost all other units of the Department of Health and Mental Hygiene, the Department of State Planning, and numerous other State agencies.

It is the responsibility of MCHPA to ensure that program units of the Department of Health and Mental Hygiene develop and implement long-range planning for their particular function. MCHPA coordinates involvement of the voluntary and private sector in this total effort.

This comprehensive health planning impact on programs manifests itself in various ways:

a) Setting program priorities and resolving interprogram planning conflicts: The Advisory Council advises the Secretary of Health and Mental Hygiene and the MCHPA on major health policy issues, and the Agency staff is represented in all department-level decision-making.

b) Reviewing program plans in the context of the total State effort: The MCHPA reviews and approves the State plan for health services before submission for federal financial grant assistance, under Section 314(d) of the Partnership for Health Act; the State Hill-Burton Health Facilities Plan; the Mental Health Plan; the Mental Retardation Plan; and reviews the capital budget proposals of the Department of Health and Mental Hygiene.

c) Insuring the inclusion of the private and voluntary sectors in State health programs, as well as official government services facilities: A typical example involved the Agency's drafting of the State Plan for Chronic Kidney Disease Treatment Facilities and Services, for which participation was sought and obtained from Regional Medical Program's Renal Committee, the Kidney Foundations of Maryland and the National Capital Area, and from other renal specialists and practitioners. This widening of involvement by public and private sectors undoubtedly made the plan more acceptable and comprehensive.

d) Providing a channel for the consumer to have input into health programs: High priority in comprehensive health planning is given to the education of consumers to make them better informed on health issues through reports, newsletters, seminars, and meetings. Beyond the heavy consumer input on the advisory councils of the State and areawide agencies, a key element of the certification of conformance review pro-

cedure is the public hearing which encourages all viewpoints to be voiced.

e) Determining the kinds of information and data required to develop comprehensive health planning and providing these data when other sources are not available: The MCHPA spawned the development of the State Center for Health Statistics now operational within the Department of Health and Mental Hygiene. This Center has the responsibility to coordinate the acquisition of health statistics and simplify their utilization.

Another major activity of the MCHPA this past year was the comprehensive study of the Ocean City-Assateague area to determine the needs for health services in this resort area with a summer population that frequently exceeds 100,000 and with a winter population of fewer than 2,000. In addition to determining need, the study identified present resources and developed alternative ways to meet these needs. The study is a model of cooperative effort among governmental levels and the private sector—the very essence of the Partnership for Health Act envisioned by the Congress. Governmental agencies involved were the Mayor's Ocean City Medical Commission, the Health Planning Council of the Eastern Shore, the MCHPA and other divisions of the Department of Health and Mental Hygiene. Private sector involvement included the consultants, who were from the School of Hygiene and Public Health of Johns Hopkins University; local medical practitioners and institutions serving the Ocean City area; and the Boise-Cascade Corporation, which contributed without charge a number of employees as interviewers.

The design, careful data collection, and comprehensiveness of the study support the expectation that the conclusions and recommendations will serve the Ocean City Medical Commission and the Health Planning Council of the Eastern Shore Inc in developing an effective, economical long-range plan to serve this area's health needs.

The recommendations and conclusions have led to immediate partial implementation of improved patient services, particularly through the opening of two first-aid stations in the summer of 1972. It is estimated that 3,000 persons were aided by these stations, and all but an estimated 503 patients were treated for minor problems without the necessity of visiting already overcrowded doctors' offices in the resort. This served to reduce unreasonable waiting time for patients consulting physicians for more serious services.

Budgeting and financing for further and longer-range implementation of the plan have been arranged; communications systems have been implemented; and purchasing and emergency systems have been arranged through Peninsula General Hospital in Salisbury.

The data collected are also being made available to other agencies in the Ocean City area concerned with economic growth, prevention of beach erosion and other purposes.

f) Providing a forum for bringing different and often independent members of the health industry to work together on common problems or programs requiring multiple cooperation. For example, task forces with broad representation have assisted the Advisory Council in developing recommendations and policies for health services cost review, HMOs, and ambulatory care. The Advisory Council's 21-page position statement on Health Maintenance Organizations has been given wide coverage in the press and over 7,000 copies have been distributed to interested parties throughout the State. Requests for copies of the statement have come from all parts of the country.

Just as State comprehensive health planning is dependent upon a strong areawide planning component, it is also dependent upon strong program planning. There are literally hundreds of functional or so-called "categorical" health care and environmental health programs. These are the operating program activities under both public and private sponsorship in many State and local agencies and organizations. Each of these must do its own program planning for which comprehensive health planning in no way substitutes.

The focus of comprehensive health planning is on total health needs—rather than on those needs related to a given problem, such as alcoholism; or to a particular type of service, such as chronic disease care; or to a specific population group, such as children or the poor.

These program plans are incorporated into the State planning process and are used by the MCHPA to set priorities and to array alternatives for allocating the scarce resources of manpower, facilities, and dollars. In recent months MCHPA staff has participated in program planning for tuberculosis control, chronic renal disease, drug abuse, hospital construction, mental health, developmental disabilities, services to the aged, air pollution control, and a State laboratory system, among others.

To be continued

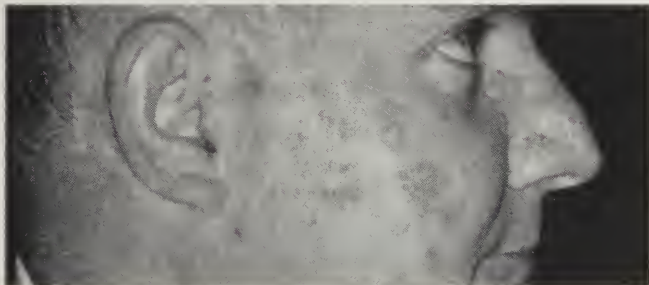
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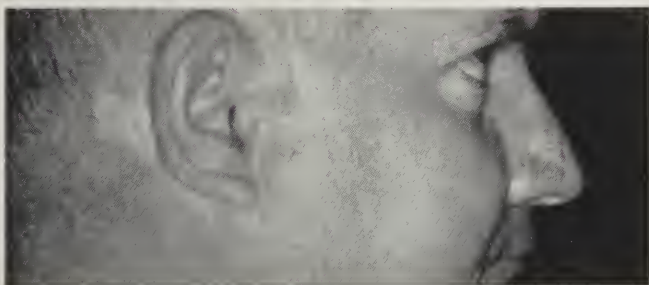
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BLOOD DISEASES OF INFANCY AND CHILDHOOD, by Carl H Smith MD, and Denis R Miller MD, The CV Mosby Co, St Louis, 1972.

In the third edition of this publication, the objectives stated in the preceding edition remain unchanged. They are to provide an opportunity to introduce newer developments in pediatric hematology, to revise much of the text in the light of newer concepts, and to review current knowledge in this field. It does this well.

PERSUASION AND HEALING, by Jerome D Frank MD, Johns Hopkins Univ Press, Baltimore & London, 1973.

John C Whitehorn MD wrote the foreword to the first edition of this book when it was published in 1960. At that time he referred to Dr Frank as being a person who "devoted himself, shrewdly, to the task of observing and understanding psychotherapy."

This book attempts to explore the ingredients that account for the effectiveness of psychotherapy in its many different forms. Dr Frank indicates that features common to all types of psychotherapy combat a major source of the distress and disability of those persons seeking such help. He then goes on to attempt to prove the point that it is worthwhile to explore features shared by all psychotherapists because evaluation of the differential effectiveness of different techniques, if any, will depend to a large extent on one's ability to determine the effects of those features common to all.

He gives appreciation in his comments to all those who assisted him in his update of the previous publication—members who are probably well-known to readers of this book in this area.

LABORATORY MEDICINE, HEMATOLOGY, fourth edition, by John B Miale MD, The CV Mosby Co, St Louis, 1972.

The contents of this book run from anemia to transfusions of blood. It is a comprehensive text that does not overlook any aspect of laboratory medicine or hematology. It is well worth purchasing, particularly for the Pathologist, as a reference manual or for an update of knowledge.

HANDBOOK OF PEDIATRICS, by Henry K Silver MD, C Henry Kempe MD, and Henry B Bruyn MD; Lange Medical Publications, Los Altos Calif, 1973.

The format and objectives of the tenth edition of this paperback publication remain the same as in previous issues. It presents to the medical student and practicing physician a concise and readily available digest of material necessary for the diagnosis and management of pediatric disorders. As a supplement to standard textbooks and reference works, it serves this purpose well.



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SYNTHROID® (sodium levothyroxine) is pure synthetic T₄, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T₃ is more fickle. Sometimes it binds. Sometimes it doesn't. T₄ more *predictably* binds to protein.

No calculations are needed, test interpretation is simple.

Any of the commonly used T₄ thyroid function tests (P.B.I., T₄ By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T₄ because they *all* measure T₄. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

(1) The onset of action of T₄ is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)¹; (2) since SYNTHROID contains only T₄, the potential for metabolic surges traceable to more potent iodides (T₃) is eliminated.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T ₄ By Column	Less than 3 mcg %	7-9 mcg %
T ₃ (Resin)	Less than 25%	27-35%
T ₃ (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %



AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

Choose the Smooth Road...to thyroid replacement therapy



PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine (T_4) is, as you know, the major circulating hormone produced by the thyroid gland. T_3 is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that T_4 is converted by the body to T_3 . In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling². T_4 does convert to T_3 , though the precise quantities are still being studied.

The conversion has been clinically demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of T_3 in these patients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3 ?

Very simple. T_3 costs more to make synthetically than does T_4 . So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID³ because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latlouis, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyrotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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Zip

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdose may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdose appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

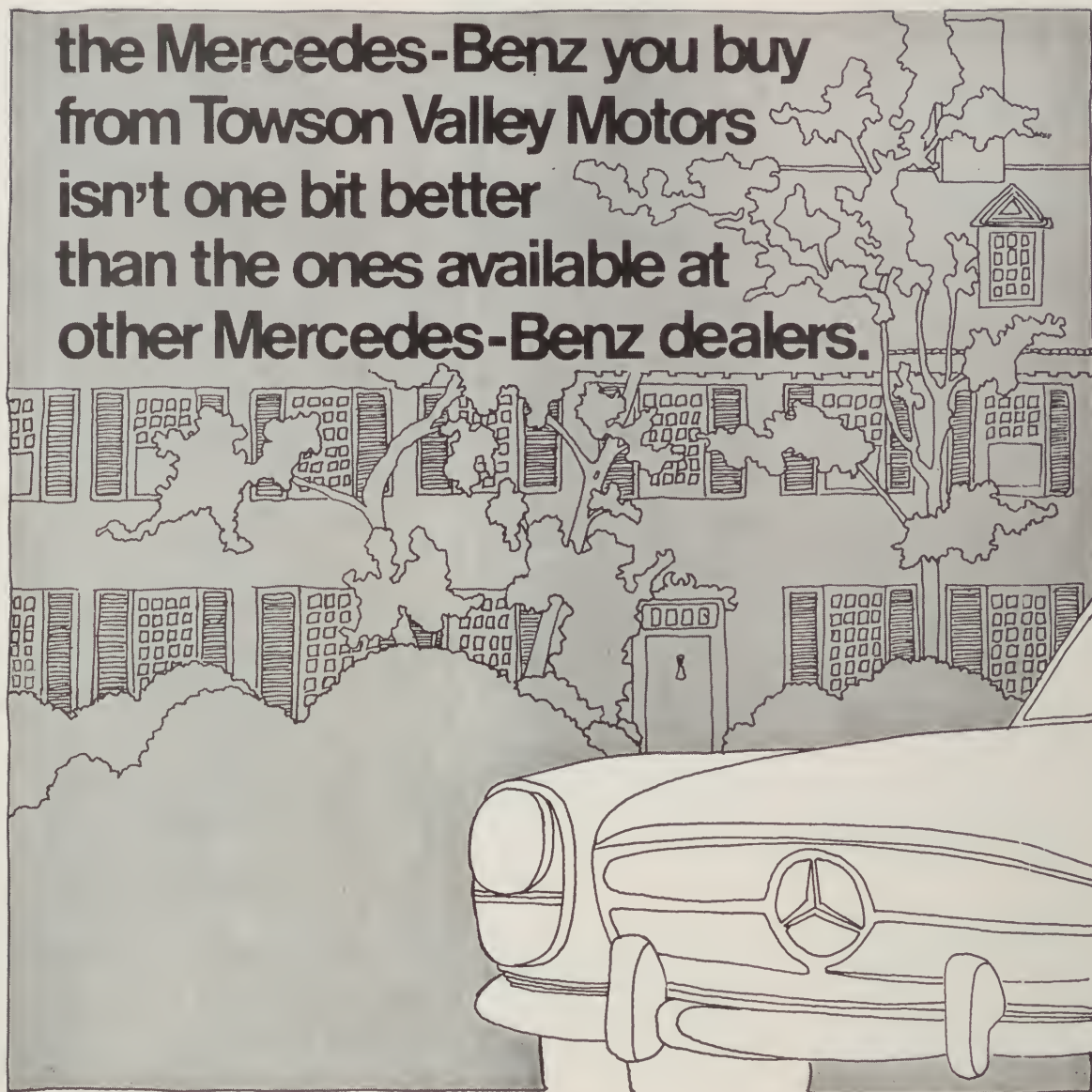
Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



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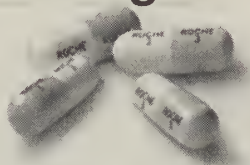
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Librium® 25 mg
(chlordiazepoxide HCl)
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Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



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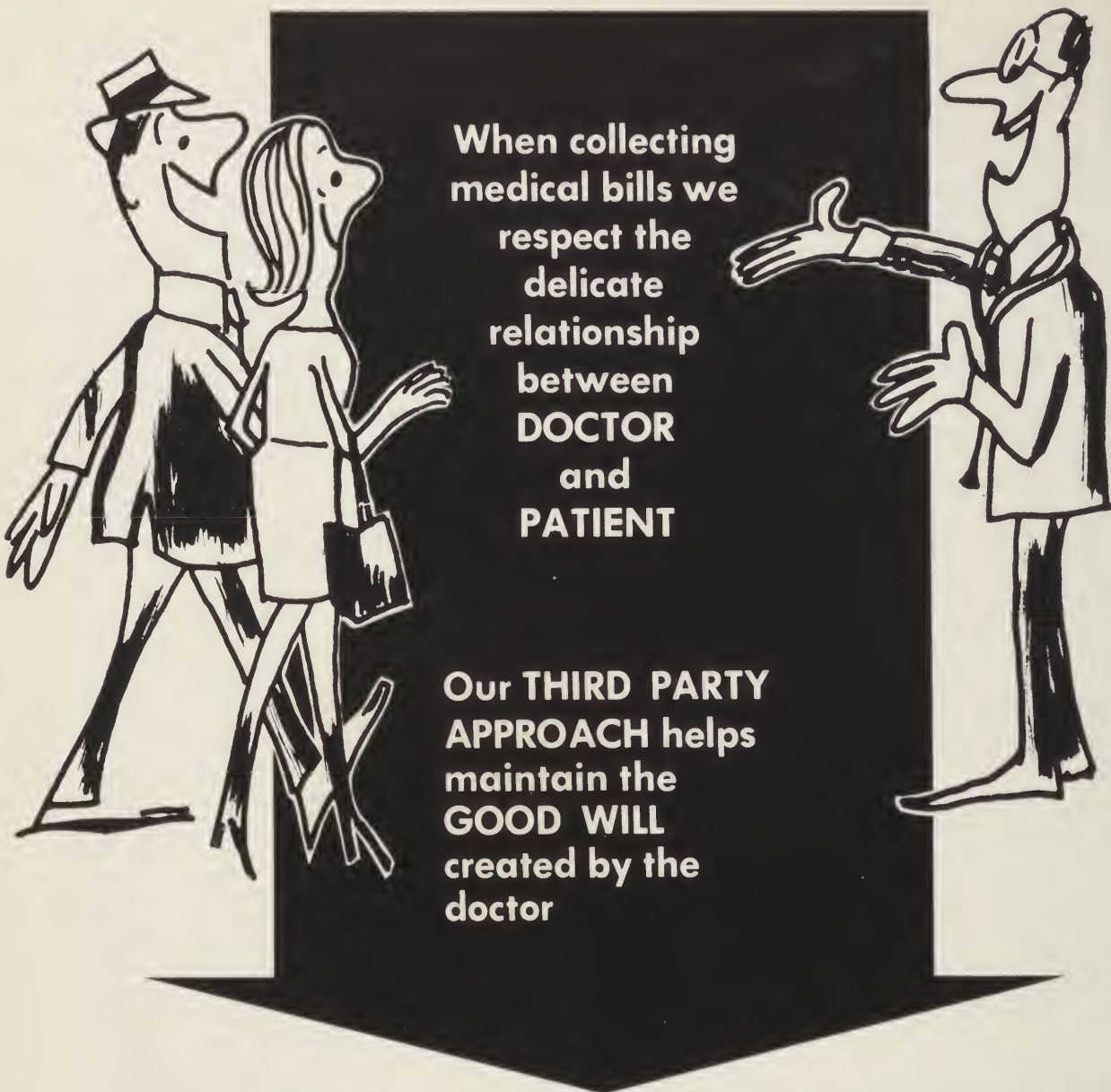
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MEDICAL JOURNAL

VOLUME 22 AUGUST 1973 NUMBER 8

IMPORTANT NOTE: Delegates and Alternates are reminded to bring their copy of this Journal with them to the Semiannual Session, Saturday, Sept 15, 1973 at the Faculty Building, as the Annual Reports will not be published separately.

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COVER—Apropos to the Transactions Issue, the series on Maryland hospitals is again interrupted to repicture the Faculty Building.



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and a few may need counseling
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Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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To help you manage excessive psychic tension

your medical faculty at work

by John Sargeant,
Executive Director

The Executive Committee met on Thursday, May 24, 1973 and took the following actions:

1. Authorized the President to form an Ad Hoc Committee, as requested by Senate Joint Resolution 49 adopted by the General Assembly, calling for a study of medical conditions in State penal institutions.
2. Declined to conduct a similar study of State juvenile detention institutions at this time.
3. Approved the following recommendation of the Committee on Emergency Medical Services, and communicated this to the Montgomery County Medical Society:
Transportation of injured persons by helicopter from Montgomery County without evaluation by a physician represents an abrupt departure from current accepted medical practice in Montgomery County. The Montgomery County Medical Society should be supported in its attempts to evolve rapidly an improved regional emergency medical system. The Faculty recommends that Montgomery County also speedily develop recording and evaluation mechanisms to judge the effectiveness of such an evolving system.
4. Authorized communication with the US Department of HEW to offer cooperation in implementation of a statewide conference on PSROs, as originated by the Montgomery and Prince George's Foundations for Medical Care; and expressed its desire to work closely with these foundations in such a conference.
5. Authorized formation of an Ad Hoc Liaison Committee on Pharmacy for the purpose of discussing the drug substitution bill and other related matters.
6. Declined to adopt a policy position regarding therapeutic abortions as suggested by the Catholic diocese, on the basis that State law sufficiently covered this area of concern.
7. Declined to amend or reconsider the position on acupuncture adopted at the April 12, 1973 Executive Committee meeting.
8. Tabled a recommendation of the Peer Review Committee that third-party carriers be assessed for administrative costs of peer review activity.
9. Requested the Professional Medical Services Committee to report on any progress made in connection with the resolution adopted by the House in September 1970 that:
". . . the committee collect valid data concerning current charges for physicians' services based on usual and customary fees charged private patients throughout the State of Maryland."
10. Declined to change the date of the component society officers meeting set for Thursday, Sept 13, 1973.
11. Authorized submission of several names for appointment of one to the Air Quality Control Advisory Council with voice but no vote.
12. Authorized the following to serve as a Retirement Committee for the Employees Pension Program:

Treasurer
Secretary
Executive Director
13. Amended the Nurses Protocol as follows:
Delete: "The responsibilities of the nurse practitioner in collaboration with the physician include the following:"
Substitute: "The following services can be delegated by a physician:"
Change the paragraph to read ". . . She participates jointly (with) BY THE DELEGATION OF the physician . . ."

14. Declined to call a special Council session, requested by the Prince George's Foundation for Medical Care, to consider and act on proposed bylaw changes for the Maryland Foundation for Health Care, as adopted by the Foundation board.

The Physician/Patient Relations Committee, at its meeting on May 23, 1973, took, among others, the following actions:

1. Expressed concern that some physicians indicate on return-to-work slips the diagnosis made of the illness the patient has. It has been learned that personnel departments later utilize this information to the disadvantage of the patient when reductions in force are implemented. Physicians should be aware of this possibility and only provide such diagnosis if the patient has given permission to do so.
2. Also expressed concern over predating of return-to-work slips that excuse a patient from his work chores for a set period of time. The patient is frequently not seen prior to being authorized to return to work; and, frequently, misses more work than may be necessary because of his illness. Physicians are urged to monitor such practices, if they exist, and to be sure of their legal responsibilities in this area.
3. Determined that physicians have no responsibility to accept multiphasic screening reports on their patients (or persons not their patients) that are conducted on a mass basis by organizations selling this service to employers, unions, or employees. Physicians are cautioned that they should be fully aware of the testing corporation's reliability as well as knowing by whom and how the interpretations are made. If physicians accept such reports and it is later found that a positive result that should have been followed up has not been pursued, there may be a potential legal problem.



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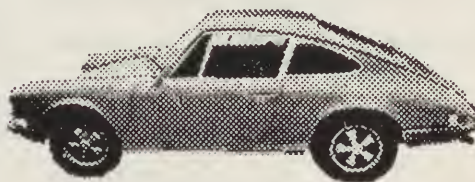
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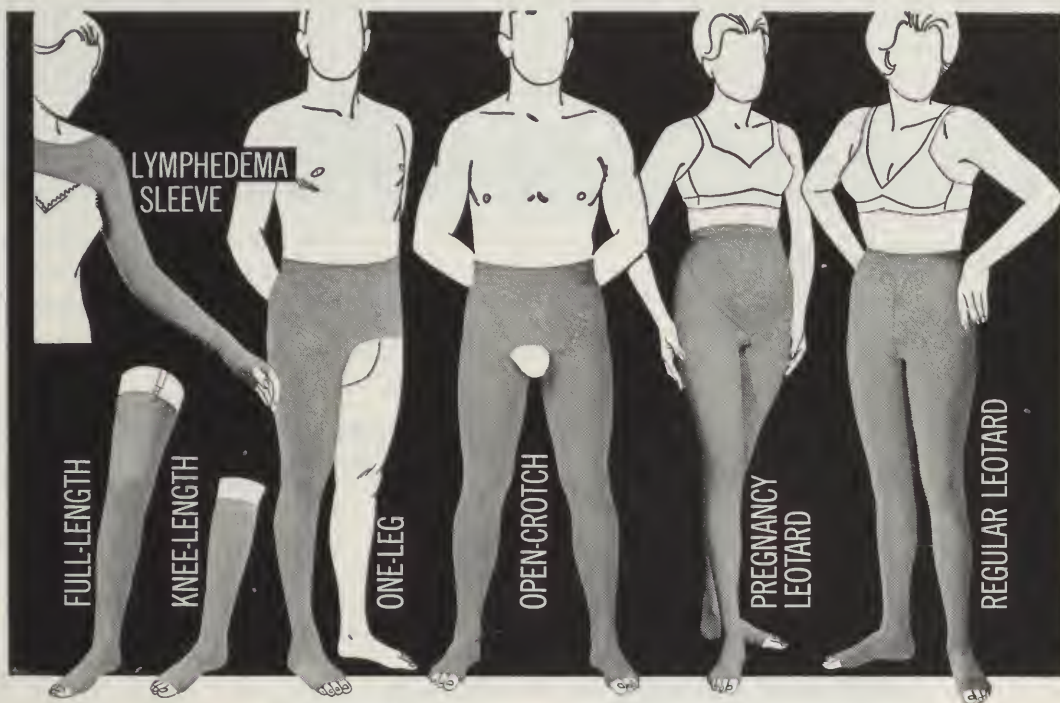
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Doctors take note...

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| Sep | 19-23 | Med-Chi Semianl Mtg , Baltimore & Mexico City |
| Sep | 29 | 1st Invitational Symposium on Sero-Diagnosis of Cancer , Bethesda Md. Sponsors: College of Amer Pathologists, Amer Society of Clinical Pathologists, and Armed Forces Radiobiology Research Institute. Contact: Symposium, College of Amer Pathologists, 1775 K St NW, Washington DC 20006, phone (202) 466-2121 |
| Oct | 20-21 | Maryland Heart Assoc , anl mtg, Washington, Route 70-S, Gaithersburg Md. Contact: Heart Assoc of Md, 201 N Charles St, Baltimore Md 21201 |
| Oct | 29-Nov 2 | 6th Materials Research Symposium , National Bureau of Standards, Gaithersburg Md. Contact: SRM Symposium, National Bureau of Standards, Washington DC 20234 |

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- | | | |
|-----|-------|--|
| Sep | 12-14 | Diagnosis & Mgt of Infectious Diseases , Howard Univ Col of Med, Washington |
| Sep | 17-21 | Advances in Internal Med , Univ of California, San Francisco |
| Sep | 19-21 | Clinical Hepmatology for the Internist, Patho-physiology Diagnosis & Treatment , Mayo Clinic, Rochester |
| Sep | 19-21 | Mechanisms of Hormone Action , Vanderbilt Univ Sch of Med, Nashville |

MISCELLANEOUS MEETINGS

- | | | |
|-----|-------|--|
| Sep | | Institute for Comprehensive Medicine , 2-day seminars on Mgt of Sexual & Marital Inadequacy: 15-16, Chicago Sheraton Hotel, Chicago; 19-20 Regency Hotel, Atlanta; 22-23, Royal Sonesta Hotel, New Orleans, Contact: Dr W S Kroger, 9735 Wilshire Blvd, Beverly Hills Calif 90212 |
| Sep | 6-8 | Basic Review of Hand Surgery , Americana Hotel, Miami Beach. Sponsors: Amer Soc for Surgery of the Hand & Univ of Miami Sch of Med. Contact: Div of Continuing Educ, Univ of Miami Sch of Med, P0 Box 875, Biscayne Annex, Miami Fla 33152 |
| Sep | 16-20 | Amer Acad of Ophthalmology & Otolaryngology , anl mtg, Conv Cen, Dallas. Contact: Dr C M Kos, AAOO, 15 Second St SW, Rochester Minn 55901 |
| Sep | 16-20 | Linking of Education & Health Care Delivery , anl mtg, Amer Assoc of Med Clinics, Century Plaza Hotel, Los Angeles. Contact: AAMC, PO Box 949, 719 Prince St, Alexandria VA 22313 |
| Sep | 17-18 | 33rd Anl Congress on Occupational Health , Ben Franklin Hotel, Philadelphia. Sponsors: AMA Dept Environmental, Public & Occupational Hlth; Amer Col of Radiology; Natl Inst for Occupational Safety & Hlth, DHEW. Contact: AMA, 535 N Dearborn St, Chicago Ill 60610 |
| Sep | 19-20 | Topics in Perinatal Medicine , Newborn Symposium, Durham NC. Contact: Dr G W Brumley, Dir of Gynecologic Oncology, PO Box 3079, Duke Univ Med Cen, Durham NC 27710 |
| Sep | 21-22 | 1973 Symposium on Gyn Malignancy & Surgery , Durham NC. Contact: Dr W T Creasman, Dir of Gynsecologic Oncology, PO Box 3079, Duke Univ Med Cen, Durham NC 27710 |
| Sep | 24-28 | OB-GYN Workshop , Chicago. Sponsor: Amer Soc of Clinical Pathologists. Contact: Educ Cen Programs, ASCP, 2100 W Harrison St, Chicago Ill 60612 |
| Oct | 8-12 | Clinical & Histopathological Survey of OB-GYN , Livingston NJ. Contact: Dr J L Breen, Dept of OB-GYN, St Barnabas Med Cen, Livingston NJ 07039 |
| Oct | 22-26 | Diagnostic Radiology , New York City. Sponsor: NYU Med Cen. Contact: Office of Recorder, NYU Med Cen, Medical Sciences Bldg, 550 First Ave, New York NY 10016 |

STEERING COMMITTEE ON IMMUNIZATION PRACTICES

of the
Medical and Chirurgical Faculty of Maryland
and the

Maryland Department of Health and Mental Hygiene

Recommended Schedule of Immunization & Tuberculin Testing

(Revised June 1973)

Approx Age of Child	Minimum Interval Between Doses	Vaccines	Skin Tests
1) 2-3 mos	Start	DTP ^{1,2} OPV ₃ ^{2,3}	
2) 3-4 mos	4 wks after 1	1 DTP	
3) 4-5 mos	4 wks after 2	2 DTP, OPV ₃	
4) 8-10 mos			Tuberculin 7
5) 12-16 mos		Measles ^{4,5} Rubella ⁵ Mumps ^{5,6} DTP, OPV ₃	
6) 4-6 yrs		DTP OP ₃ OPV ₃	
7) 15 yrs		Td (adult) Tuberculin 7 DTP	

Abbreviations

DTP=Diphtheria and Tetanus toxoids and Pertussis vaccine.

OPV₃=Trivalent Oral Polio vaccine.

Td=Tetanus and Diphtheria toxoids, adult type.

The Steering Committee on Immunization Practices and the Maryland Department of Health & Mental Hygiene will issue periodically a schedule of recommended immunizations for infants and children. This schedule is revised and brought up to date to conform with the latest recommendations of the Public Health Service Advisory Committee on Immunization Practices and the American Academy of Pediatrics.

If followed, it will give the child adequate protection early in life against the diseases for which vaccines are available. It should serve as a flexible guide which may be modified according to circumstances, without jeopardizing the objective of completing the schedule in as brief a space of time as is compatible with the procedures governing the administration of each type of vaccine.

IMMUNIZATION AND TUBERCULIN TESTING

Notes

- 1) When a child begins the primary series of immunizations at an older age than two months, this schedule may be somewhat condensed provided the minimum interval of one month between doses of DTP and eight weeks between the first and second doses of OPV₃ are observed.
- 2) If the primary OPV₃ or DTP series are interrupted for more than the scheduled interval, it is not necessary to begin the series again. Complete the three OPV₃ doses or the four DTP doses regardless of the time which has elapsed since the last dose, always observing the *minimum* interval between doses.
- 3) When children who have received previous Salk vaccine (IPV) are given a full course of OPV₃ (two doses separated by 6-8 weeks and a third dose 8-12 months later), booster doses of IPV are no longer necessary.
- 4) Infants who were given live, attenuated measles virus vaccine with measles immune globulin before 12 months of age, should be revaccinated. If it is uncertain whether measles immune globulin was administered with the live, attenuated measles virus vaccine, the individual should still be revaccinated. Individuals who have previously been given inactivated measles vaccine should also be given the live virus vaccine.
- 5) Combination attenuated, live virus vaccines of measles — rubella, and measles — mumps — rubella, are currently licensed. Either combination vaccine may be given at 12 months of age. As an alternative to using the combination vaccines, two or all three individual vaccines containing the same virus or different virus strains in combined form (further attenuated measles, mumps, rubella) may be given by separate injections on the same occasion; eg, Schwartz strain of measles vaccine and the Cenderhill strain of rubella vaccine can be safely and effectively administered at the same time. In addition, OPV₃ can be administered at the same session as measles, mumps, and rubella vaccine.
- 6) Routine immunization with mumps vaccine should be given the lowest priority except for males approaching puberty who have not already had the natural infection and for institutionalized children older than one year where the threat of an outbreak exists.
- 7) When an immunization and a tuberculin test are scheduled at the same time, the tuberculin test should be given first and the immunization can follow at the time the test is read (48-72 hours). If immunization with a live virus vaccine must precede a tuberculin test, at least two months should separate them.

Precautions and Contraindications

A) Infants and Children

- 1) An acute febrile illness is reason to defer immunization until the infection is properly controlled. *Minor* infections not associated with febrile reactions, such as the common cold, are *not* contraindications.
- 2) DTP may be given simultaneously with any live virus vaccine.
- 3) DTP is not given to children beyond the age of six years. For persons of seven years or older, the *adult type* of tetanus diphtheria toxoids (Td) should be used for the primary series (two doses 4-6 weeks apart with a reinforcing dose approximately one year after the second) and for single booster doses.
- 4) Smallpox vaccination may be required for foreign travel. Smallpox vaccine should not be given to individuals with eczema, various dermatoses or extensive wounds or burns, and to children whose household contacts may have a skin disease.
- 5) Children with leukemia, lymphoma, and other reticuloendothelial malignancies; dysgammaglobulinemia; on therapy with immunosuppressive drugs such as steroids, or receiving radiation should not be immunized with a live virus vaccine.
- 6) Children hypersensitive to any component of a specific vaccine should not be immunized with that vaccine. An alternate brand of that vaccine not containing the component to which the individual is sensitive should be used.
- 7) Children with a positive tuberculin reaction should be given the live virus measles vaccine *only* if they are under treatment for tuberculosis. Measles immunization should not be postponed, however, if for some reason a tuberculin test has not been previously performed.

B) Adults

- 1) Although OPV³ is the preferred vaccine against polio, its use should, in general be limited to persons who are under 19 years of age. For individuals 19 or older, *no routine* immunization with polio vaccine is necessary. However, if an adult is at increased risk of being exposed to polio infection, then OPV³ may be used for primary immunization (two doses separated by 6-8 weeks and a third dose 8-12 months later) and booster doses. If either primary immunization or a booster dose of polio vaccine is indicated for a pregnant woman of any age because of increased risk of exposure, OPV³ may be used.
- 2) The live virus vaccines against measles, smallpox, rubella, and mumps are contraindicated for pregnant women.
- 3) Routine boosters with *adult type* Td should be given at ten-year intervals after the age of six. More frequent routine booster doses are not indicated and may be associated with increased frequency and severity of reactions. Plain tetanus toxoid may be used for primary immunization of adults and in prophylactic wound management if the individual is suspected of being hypersensitive to the diphtheria component.
- 4) Smallpox vaccination is recommended every three years for persons in occupations at high risk to exposure and travel to certain foreign countries.

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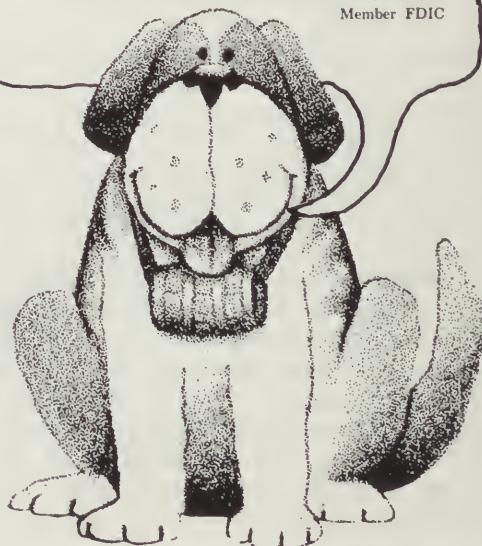
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Dr Moxley

John H Moxley III MD became Vice Chancellor for Health Sciences and Dean of the School of Medicine at the University of California in San Diego on July 1.

He had served as Dean of the University of Maryland School of Medicine since July 1969. Age 34 at the time, he was one of the youngest medical school deans in the country, according to Dr Albin O Kuhn, Chancellor of the school's Baltimore campus.

In accepting his resignation with reluctance, Dr Kuhn had this to say: "Dean Moxley has given outstanding leadership during the past four years in the continuing improvement of the work of the School of Medicine. During his tenure, much has been accomplished in fully recognizing the needs associated with the increased enrollment of 200 incoming students each year, and in preparing for this change."

The School of Medicine at San Diego is one of five medical schools in the University of California's nine-campus system. The school, which has over 150 full-time faculty members, is a very young one, and graduated its second class in June. It is noted for its strength in the basic sci-

Doctors in the News

ences, and especially for its innovative programs, providing both students and faculty the opportunity to share the knowledge and experience of other professions.

John N Classen MD, Baltimore, has been named Chairman, Maryland Advisory Committee, American College of Surgeons. Other Maryland physician members, all Baltimoreans, include **Robert C Abrams**, **George G Finney Jr**, **John E Savage**, and **Edward S Stafford**.

Robert W Gibson MD, Medical Director, Sheppard and Enoch Pratt Hospital, Towson, has been reelected Secretary of the American Psychiatric Association. This will be his second one-year term.

Baltimore City Hospitals has established a Department of Neurology, made possible by the recent reorganization and development of the Chesapeake Physicians Professional Association.

Oscar S Marin MD, formerly neurological program director of the Wilmington (Del) Medical Center, will head the new department.

A graduate of the University of Chile, he has done postgraduate work in London and Paris.

John D Morris MD, a Baltimore obstetrician-gynecologist, has been elected to a three-year term on the Blue Cross of Maryland Board of Directors.

Other physician members of the 27-member board in-

clude **Albert T Dawkins MD**, and **Richard D Young MD**.

George H Yeager MD was the recipient of the University of Maryland School of Medicine's Alumni Honor Award and Gold Key at recent Alumni Day activities.

Dr Yeager retired earlier this year as Director of University of Maryland Hospital after a distinguished 44-year career with the University. He was a member of the medical school's 1929 graduating class.

He is also a Past President of Med-Chi (1955) and Editor of the *Maryland State Medical Journal* (1952-1966).

The Baltimore County Department of Health's Bureau of Mental Health has employed **Kay Cutler MD** as full-time psychiatrist at the Eastern Community Mental Health Center in Essex.

He acquired his MD at the University of Utah Medical School and his MPH at Johns Hopkins. His psychiatry residency was completed at Sheppard-Pratt.

David L Jackson MD, a Resident in neurology at the Johns Hopkins Hospital, has been named a White House Fellow for 1973-1974.

Dr Jackson, 33, was one of 18 Fellows selected from a field of over 200 applicants. White House Fellows serve one year on the staff of the President or Cabinet, beginning in September.

Others appointed included **Delano Meriwether**, 30, a hematologist and leading track sprinter, formerly of Baltimore and now working in Boston.

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Medical Miscellany

Mercy Hospital Restructures

Nursing Education Programs

Baltimore's Mercy Hospital, in a cooperative venture with the University of Maryland School of Nursing and the Community College of Baltimore, will restructure its nursing education program starting with the fall term in 1974. They will provide a clinical base for the two schools.

The programs will replace the 74-year-old Mercy Hospital School of Nursing, which will figuratively close its doors with graduation of its final class in May 1974. It will have graduated more than 2,400 nurses.

Principally, the University will offer a BS in nursing upon successful completion of a four-year collegiate program. Community College will institute a flexible two-year Associate of Arts degree program, again making use of the Mercy Center for clinical practice.

In making the announcement, Sister Mary Thomas, President, Mercy Hospital, said: "It always has been the aim of Mercy to provide our community with the best nurses in the country; that will continue to be our goal in the future."

Information about the two programs may be obtained from the Department of Nursing Education, Mercy Hospital Clinical Center, 301 St Paul St, Baltimore Md 21202.

Management Workshops

Practice management workshops will be offered by the AMA across the country this year and in 1974. The AMA will make its workshop program available to state medical societies and will assist the state societies in conducting the training sessions for young physicians planning to go into private practice. Ten workshops will be available in 1973 and 20 next year.

The AMA recently completed an experimental series of six such workshops at AMA Headquarters. Workshops will be limited to 25 participants and registration fees of \$35 for AMA members and \$60 for non-members will be charged. Direct inquiries to Dept of Practice Management, AMA Headquarters, 535 N Dearborn St, Chicago Ill 60610.

Lockyer Heads Great Oaks

Clifford P Lockyer, who has earned a nationwide reputation in the development of comprehensive, community-oriented programs for the mentally retarded while serving as superintendent of a regional center in Connecticut, has been appointed Superintendent of the Great Oaks Center in Silver Spring.

Gynecology Chair Pledged

For Johns Hopkins

A pledge for the establishment of a professorial chair in gynecological pathology at the Johns Hopkins University has been made by Dr Richard W TeLinde, a prominent Baltimore gynecologist.

The pledge, announced by President Steven Muller, is in response to the recently inaugurated Hopkins Hundreds campaign to raise \$100 million for the Johns Hopkins Institutions, half of which will go to the establishment of 50 named professorial chairs.

Dr TeLinde is Professor Emeritus of Gynecology at the Johns Hopkins School of Medicine, where he served for 21 years as Chairman of the Department of Gynecology.

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Johns Hopkins Changes Children's Outpatient Services

Outpatient services for children have been moved from the old Harriet Lane Home into the new Edwards A Park Building on E Monument St by the Johns Hopkins Department of Pediatrics.

Pediatric medical emergency services are now provided on the first floor of the Park Bldg on a 24-hour basis.

The Children's Orthopedic Clinic is also located on the first floor of the Park Bldg.

Baltimore-area physicians who treat children are reminded that if they have patients seen in any of these areas, a copy of the patient's emergency evaluation will be sent to them upon request.

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Health Care Dollars

Expenditures for health care totaled \$83,417,000,000 in 1972, according to statistics published in 73 *Socioeconomic Issues of Health*, the "blue book" of the AMA's Center for Health Services Research and Development. Of the total spending, \$77,291,000,000 went for hospital care and \$32,460,000,000 went for physicians' services.

Per capita expenditures in 1972 were \$153.38 for hospital care and \$76.31 for physicians' services.

Copies of the book are available for purchase from the AMA, 535 N Dearborn St, Chicago Ill 60610.

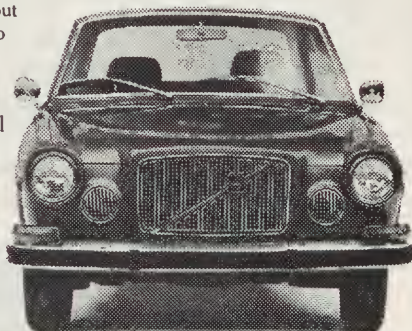
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executive director's newsletter

August 1973

NEW
MED-CHI
PAMPHLET

The Public Relations Committee has developed a pamphlet about the Faculty and its responsibilities and functions. Copies are available through the Faculty office.

Currently, they are being used for mail enclosures with all mail addressed to the general public.

NEW PRICE
CONTROL
PUBLICATIONS

Copies of pamphlets and publications dealing with price controls for Physicians and Dentists are available through the IRS, Economic Stabilization Division, at PO Box 1456, Baltimore Md 21203, or telephoning (301) 962-4000.

REVISED
FACULTY
PAMPHLETS

Newly revised Faculty pamphlets, Laws, Rules and Regulations With Which Physicians Must Comply and Compendium of Decisions of Medical and Chirurgical Faculty of the State of Maryland Dealing With Ethics, Propriety and Legality Governing the Practice of Medicine in Maryland are currently being printed.

Copies may be obtained through the Faculty office.

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Regulations are now in effect in connection with the prescribing and dispensing of Methadone, Amphetamines, and Methamphetamines. Physicians are strictly controlled with respect to the use of these drugs and pharmacists are not permitted to fill Rx for them without adequate documentation as to their use.

Full details can be obtained through the Faculty office.

MISS EDGAR
DIES

Miss S Jeanette Edgar, a long-time employee of the Faculty from 1927 to 1960, died in her sleep on May 12 1973. Miss Edgar had been in retirement since age 66.

FREE
PAMPHLETS
AVAILABLE

The American Medical Association has advised that free pamphlets are available from the Department of Community Health on the following position statements of the AMA:

Statement on Free Clinics
Statement on Health Outreach
Committee on Health Care of the Poor: Progress Report

Requests should be addressed as indicated to 535 N Dearborn St, Chicago Ill 60610.

SCHOOL
IMMUNIZATION
FORMS

The Faculty reaffirms its support of the importance of family physicians and pediatricians completing immunization forms for children prior to admission to school. (Regulations are printed elsewhere in this Journal).

PUBLIC
SPEAKING
SEMINAR

A public speaking seminar cosponsored by the Faculty and the American Medical Association will be held

Thursday, Nov 1, 1973, from 9:00 AM to 5:00 PM

As in the past, the seminar includes discussions on speech fundamentals, speech delivery principles, and speech organization. It also includes brief recording and playback of video tapes to see and hear yourself before an audience.

Attendance is limited; advance registrations are currently being accepted. Let the Faculty office know of your interest. A nominal registration fee will be charged; it includes luncheon.

TREE
OF
HIPPOCRATES

A young tree grown from a seed of the great Tree of Hippocrates, found on the Greek Island of Cos, is now growing in the Faculty building. Donated by Schering Corporation, the trees have been given to medical societies and medical schools throughout the US.

PRACTICE
WORKSHOP

The Faculty, in cooperation with the American Medical Association, is planning to schedule a Practice Workshop sometime during the next 12 months. Such a workshop includes office management techniques and other data useful to the physician.

If interested, please let the Faculty office know so that you can be notified when a final date is set.


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Dr Patterson Receives Community Service Award

A highlight of the 175th Annual Meeting was the presentation of the Community Service Award to Theodore C Patterson MD, Dundalk physician, by DeWitt E DeLawter MD, Faculty President, at the Presidential Banquet.

This award has been made annually since 1964 when the A H Robins Co and Med-Chi teamed to provide a plaque to the physician who best exemplifies the currently active, community-minded professional.

Here is a part of what Dr DeLawter had to say about Dr Patterson in making the award:

"Dr Patterson is a man for whom community involvement is more than an occasional gesture. To him, his community is as much a part of his life style as is his family or his profession.

"In Dundalk it's as common to say 'Let's get Ted to do it' as it is in other places to leave it up to that mythical George. Fortunately, his unending efforts do not go unrecognized. In 1968 he was honored by the Dundalk Jaycees with their Distinguished Service Award for Community Service. The Dundalk United Methodist Church cited him for community service in 1971 and made him an honorary member. Provident Hospital has also hailed his efforts with a plaque.

"A native of Sparrows Point, there was no doubt when he set his sights on a medical degree that he would come back to his community to practice medicine and community healing. He holds an AB from Morgan and an MD from the University of Maryland School of Medicine.

"His medical background is, perhaps, not unusual. But his involvement in his community is—especially for a young man (now 40) who has a busy family practice plus a wife and three children.

"He has served on the boards of the American Cancer Society, Health and Welfare Council, Baltimore County Senior Citizens; also the advisory boards of Essex and Dundalk Community Colleges, Turner Child Development Center, and the Merrit Point PTA.

"He has been a member of the Baltimore County Committee on Education, Patapsco Neck Historical Society, Dundalk Jaycees, Dundalk Community Council, Dundalk Human Relations Committee (chairman), Baltimore County League for Human Rights. One of a few men so honored, he is a member-at-large of the Federated Garden Clubs of Maryland.

"Ted served on the Building Fund Committee for the new Franklin Square Hospital. He is a



HONORED—Theodore C Patterson MD, left, accepts the Community Service Award from DeWitt E DeLawter MD, then Faculty President.

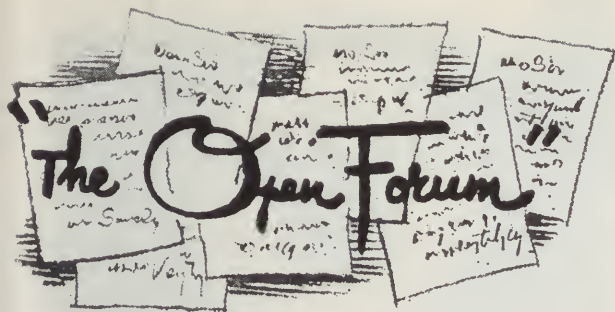
team physician at Patapsco High School and was a delegate last year to the school board nominating convention. And while we might pant from a simple reading of his involvements, he emerged after swimming two miles in the YMCA Swimathon in 1972 hardly winded, having raised over \$500 in pledges for the Dundalk YMCA.

"In his so-called spare time, he speaks at schools and clubs on the health hazards of smoking, and on VD, sex education, drugs, and race relations.

"Ted Patterson is a very volatile guy. But he does not neglect his obligations to his profession. The Baltimore County Medical Association, which nominated him, knows he is a doer, having served as Secretary, Vice President, President, Chairman of the Board, and Chairman of the Membership and Ethics committees.

"He is a family practitioner who considers that family practice includes his whole community. That is why Dr Theodore C Patterson is being presented with the 1973 Community Service Award."

Scientists at the National Institutes of Health have found a way to grow living animal cells to a density resembling natural body tissue. Current methods allow many types of human and animal cells to be grown in the laboratory, but they stop growing at concentrations much lower than that of tissue. The new method uses an "artificial circulatory network," similar to blood vessels which supplies continuous nourishment. The scientists plan to use the technique to study cancer. By altering hormones and other ingredients in the fluid that feeds the cells, they will study conditions which promote or retard the growth of various kinds of cancer tissue.



Med-Chi members are invited to write to the editor expressing their opinions or giving information on matters of mutual interest. The Editorial Board reserves the right to select or reject communications. As with other material, all correspondence will be subject to the usual editing and possible abridgement. Material should be typewritten, double spaced, of reasonable length, and not over two pages. Address: The Editor, MARYLAND STATE MEDICAL JOURNAL, 1211 Cathedral St, Baltimore Md 21201.

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Editor's Note: Mrs Williams reports that the Oath of Hippocrates used with her article is the one used by the University of Maryland School of Medicine.

Further research in Faculty files reveals two variations of the Oath, leading us to the conclusion that, like the Bible, it depends on which version you prefer reading or is most readily available.

I recently read Mrs Charles H Williams' article in our State Medical Journal on Hippocrates (pp 56-58 May 1973). I feel that it would be only fair to this great man to print his oath in its entirety as recorded in the Encyclopedia Britannica by their scholars. It should also be noted that they felt that the term "oath" should not be interpreted too narrowly. Rather, it was an ethical code or ideal and in no sense a law. It is an appeal for correct conduct but contains no threat of punishment. In one or other of its many versions, it has guided the practice of medicine for more than 2,000 years.

The following is the Oath of Hippocrates from the Encyclopedia Britannica Vol 15, p 94B:

"I will look upon him who shall have taught me this art even as one of my parents. I will share my substance with him, and I will supply his necessities, if he be in need. I will regard his offspring even as my own brethren and I will teach them this art, if they would learn it, without fee or covenant. I will impart this art by precept, by lecture and by every mode of teaching, not only to my own sons but to the sons of him who has taught me, and to disciples bound by covenant and oath, according to the Law of Medicine.

"The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion. Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrong doing or corruption, and especially from any act of seduction, of male or female, of bond or free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart there from which ought not to be noised abroad, I will keep silence thereon, counting such things to be sacred secrets."

Sincerely,

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MARYLAND'S PARTNERSHIP APPROACH TO COMPREHENSIVE HEALTH PLANNING

EUGENE H GUTHRIE MD

FREDERICK NEVINS PhD

Continued from July

The Health Facilities Certification of Conformance program has also helped to forge strong linkages. Review procedures established and decisions made in the Certification program have resulted in improved coordination of effort on the part of the several Department of Health and Mental Hygiene units responsible for portions of the total institutional licensure program. The MCHPA has initiated the establishment of the Health Facilities Processing Center which serves as a single-door entry point and communications channel for all inquiries and decisions relating to the licensure process. This will greatly simplify the process, avoid confusion, and inform the applicant on the progress of his application.

All new health facility projects proposed by institutions operated by the Department of Health and Mental Hygiene must also undergo Certification of Conformance review and approval; the State and areawide agencies have an opportunity to review the Health and Mental Hygiene capital budget before submission to the Department of State Planning and the Governor. Thus, State-operated health institutions will undergo the same review and scrutiny to assure conformance to areawide health planning as other institutions.

State Department of Planning

In relation to the Department of Planning, there are several noteworthy linkages:

a) In organizing areawide health planning agencies within Maryland, the MCHPA has made

certain to conform to the regional boundaries adopted by the Department of State Planning and has worked closely with its representatives at headquarters and in the field.

b) Where multi-purpose areawide planning agencies have already been designated under the official aegis of that Department, MCHPA moved quickly to establish those same agencies for comprehensive health planning purposes, eg, Regional Planning Council, Tri-County Council of Southern Maryland.

c) The Secretary of Health and Mental Hygiene has designated the MCHPA as its representative to assist the State Planning Department in the review of health projects as part of its clearinghouse responsibilities under the Federal Office of Management and Budget A-95 Procedure. Under this procedure, State review and comment is required on almost all proposals prior to any federal financial grant assistance. As a federal grant recipient itself, the MCHPA of course requires the A-95 approval of the State Planning Department prior to federal funding of comprehensive health planning activities.

As a planning agency, it can be said that the MCHPA is highly sensitive to the need for a comprehensive approach to planning and to the need for cooperation and coordination between and among the various State agencies. Thus, MCHPA took leadership in ensuring participation of the Department of State Planning in the newly revised program review procedures of the DHEW.

Another example of this cooperation was evidenced by the Agency and Advisory Council

championing of legislation to create the Health Services Cost Review Commission—a new State agency established by the General Assembly to disclose and make reasonable the ever-increasing costs of hospital care.

MCHPA maintains liaison with numerous other agencies of State government such as the Department of Natural Resources, Department of Economic Development, Department of Budget and Fiscal Planning, Department of Employment and Social Services and the Council for Higher Education.

Nongovernmental Relationships

Perhaps the greatest contribution of the Partnership for Health concept has been to encourage the involvement of the nongovernmental sector of the health enterprise in the comprehensive health planning process. By far the greater portion of the \$1 billion health industry in the State is from other than government sources; but in the past, the private and voluntary interests have usually been peripheral to the health-planning process. PL89-749 and Maryland Law Chapter 221, Art 41, Section 59C gave the MCHPA direct responsibility to relate to the private and nonprofit sector in developing the planning process. It is, therefore, essential for MCHPA to create active and acceptable relationships with these outside groups to accomplish comprehensive health planning for all of Maryland. These linkages are far too numerous to list, but a few key instances are noted here:

a) The MCHPA formally contracted with a multidisciplinary group (composed of health planners, lawyers, geographers, sociologists, statisticians, etc) from the federally assisted health planning training program at Johns Hopkins University to assist in the preparation of the State plan for the delivery of personal health services. A statewide project has been completed to collect and analyze available planning data and to determine the methodology to be used in preparing the plan. Guidance to the project was given by representatives of both the State and areawide agencies.

The next phase in the development of this plan involves the development of policy, the creation of areawide health plans and implementation of certain portions of the plan already completed.

Health planning students from Johns Hopkins regularly serve internships with the Agency and Agency staff often assist the training program as faculty members. It is significant also that the State plan is being developed with such full

participation and at the same time that the areawide agencies are preparing areawide plans.

b) A close relationship is maintained with the federally sponsored Maryland Regional Medical Program with reciprocal advisory council and committee representation. The RMP recently awarded a \$20,000 grant to the MCHPA to conduct a study of ambulatory health care facilities in the State, which is illustrative of the close collaboration between the two groups.

c) Health manpower planning has emphasized linkages and inputs from the wide variety of professional organizations, community programs, colleges, and disciplines active throughout the State. Task forces representing many of these have worked with the Advisory Council to develop State policy on licensing of allied health manpower. The Agency was instrumental in having the Department of Health and Mental Hygiene designated to administer the MEDIHC program (Military Experience Directed into Health Careers) for Maryland. This project, operated by the Department's Division of Manpower Development, helps former military personnel who have had training in health or medical work to find related employment or to obtain further education or training. This brings sorely needed manpower into many of Maryland's health facilities and programs.

d) The State's national leadership in health planning was recognized by the election of the MCHPA Executive Director, Dr Eugene Guthrie, to serve for two years as the first chairman of the American Academy of Comprehensive Health Planning representing the health planning agencies of the 50 states. He currently serves on the Board of Directors of the American Association of Comprehensive Health Planning, its successor organization, now representing areawide agencies and university training programs, as well as State agencies. Through this linkage, Maryland is able to exert a major influence on national comprehensive health planning policy and program.

Advisory Council Relationships

Last in this matrix of linkages, and perhaps embodying the partnership concept to the fullest extent, is the Advisory Council on Comprehensive Health Planning. One of the highest priorities of MCHPA activity has been the staffing, development, and nurturing of this Council to insure its viability and effectiveness in advising on health policy and program.

Appointed by the Governor, this 43-member body, composed of a majority of consumers to-

gether with providers of health services, comes from all walks of life and geographical regions of the State. Serving together are bankers, lawyers, educators, builders, and housewives; suburbanites and ghetto-dwellers; black and white; Eastern Shore, Baltimore, Appalachia, and metropolitan Washington; government officials, legislators, and private citizens. The health providers also come from a wide diversity of occupations and interests—private practicing physician, public health officer, hospital administrator, dentist, nurse, pharmacist, veterinarian, optometrist, health insurer, nursing home administrator, and psychiatrist. The Chairmen of the Areawide Agency Councils in the State are ex-officio members of the State Council to enhance communication between the various Councils. All of these wide-ranging backgrounds and interests are brought to bear on the issues of comprehensive health planning. Moreover, the concepts of CHP are communicated out to the total Maryland citizenry as members tie their Council experience to their daily activities and special interests.

Among the key policy issues on which the Advisory Council has given guidance to the Governor and the Secretary of Health and Mental Hygiene are the following:

a) Development and support of the legislation creating the Maryland Health Services Cost Review Commission, among the first in the nation.

b) Establishment of a policy of State financial assistance to areawide health planning agencies, first such program in the nation.

c) Establishment of policy for the development of Health Maintenance Organizations (HMO) and ambulatory health care facilities in the State.

d) Study and establishment of interim policy for the licensing of allied health manpower—Advisory Council has recommended a one-year moratorium in the licensing of new health categories during which time an in-depth study will be conducted to determine present weakness as well as long-range policy.

e) Development of a Health Facilities Plan for the State.

f) Development and review of procedures and regulations for the health facilities Certification of Conformance program.

Future Evolution

With the entry of Comprehensive Health Planning on the health scene at a time of immense change and even crisis conditions, it is only

reasonable that some basic questions have arisen which remain to be answered and may remain moot for some time to come. The very "Partnership" approach itself is a new kind of concept which leaves the adherents of strong central authority and adherents of complete local autonomy both somewhat dissatisfied.

The question of "what is a State plan" also comes to the forefront. Should the emphasis be on creating a written document with detailed specificity put together by planning experts, or on creating a viable planning process which involves those being planned for, or should it be some combination of both?

After early concentration on creating a process and an atmosphere conducive to planning in the State, the MCHPA has shifted emphasis toward the definition and documenting of a State Plan for Personal Health. A concurrent question relates to the above issue—how does the areawide plan relate to the State plan and vice versa, and how will differences between the two be resolved? In its ultimate form, the areawide plan is a product of this local planning initiative modified to reflect appropriate overall State priorities and to fit into the State plan. Conversely, areawide plans produced by the areawide agencies are the building blocks which are mortared together into the State plan. The MCHPA and the areawide agencies are mindful of these issues and are working out a *modus operandi* now while still in the initial stages of plan preparation. On the entire question of plan preparation, the MCHPA is attempting to maintain a flexible middleground approach rather than commit the Agency to a single planning method which would not be acceptable to the majority involved. This process, we believe, will permit Maryland to evolve its Comprehensive Health Planning program with maximum effectiveness.

The Certification of Conformance program has added another dimension to the development of comprehensive health planning. It has put "muscle" into the health-planning process. Planners are not just making recommendations but providing decisions as well. Moreover, the effects of this decision-making on the health-care system go beyond the simple adding of new bed-capacity, particularly when the certification process is augmented by health services cost review and rate setting in the next few years. These programs insure that health services and facilities will be of high quality, responsive to community need, and provided at reasonable cost.

Another result of the Certification program has been to greatly increase the visibility of the

State and areawide health planning agencies as several of the proposals and decisions have elicited strong community, professional, and political controversy. Particularly has this been true in the Metropolitan Washington area where the program became effective just at the time when the enormous population growth of the past two decades has spawned a near explosive catch-up effort. Health-planning control is desperately needed there to prevent creation of overlapping and competing institutions and wasting of scarce dollars. Ironically, this is the only region where the MCHPA does not have available a full-fledged areawide comprehensive health planning agency.

Lastly, the evolving areawide and State programs must constantly keep abreast of changing patterns at the federal level. Here we see a growing dependence on the comprehensive health planning mechanism in proposed new legislation affecting Medicare, Medicaid, National Health Insurance, and Health Maintenance Organizations. In short, more responsibility is in the offing with such provisions featured in the Social Security Amendments of 1972 (PL 92-603) recently enacted by the Congress.

Summary

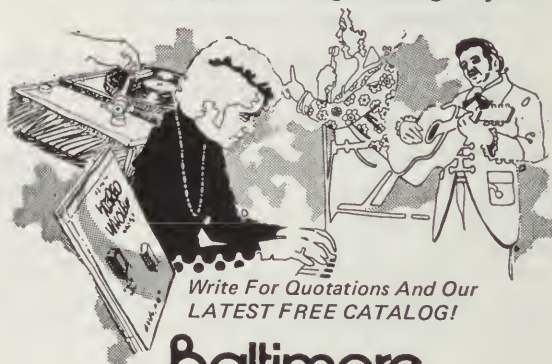
This article has attempted to set forth the framework and evolution of the comprehensive health planning system of the State of Maryland. It is a cooperative process in which each partner has its own essential role to play. Basic needs and demands for health services are defined at the local community and areawide level. This areawide CHP concept with its relative autonomy allows a maximum of direct local input and planning influence by consumers and providers at the community level. The conviction that CHP decisions emanate from within their own communities helps to assure participation in the overall planning process.

Functional program planning input rests largely with the professionals and interest groups having technical expertise in the particular program.

Finally, the MCHPA functions as convenor, coordinator, advisor, planner, and overseer of the State health planning process. Working within the context of national health goals and overall State policy, the MCHPA seeks to achieve through a comprehensive health planning system "the highest level of health attainable for every citizen of the State."

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Maryland Association of Medical Assistants

The 14th Annual Meeting of the Association was held at the Holiday Inn in Cumberland April 27-29. This was a first for the annual meeting in any locale other than Baltimore City. The beautiful mountains of Western Maryland evidently served as a magnet for attendance was great.

A welcome party, given by the President, Mrs Mabel Young, started the hectic three days of activities.

The most important discussion at the business meeting on the middle day was the forthcoming national convention, scheduled for Washington DC in October. The Maryland and Baltimore chapters, as well as individual members, will sponsor medical assistants from England.

Mrs Mary Minnick was chosen as President-elect.

The three Delegates to the national convention elected were Mabel Young, Allegany; and Lila Adams and Dorothy Walker, Baltimore.

Alternate Delegates selected were Frances Fairley and Jean Jacobson, Baltimore; and Betsy Franch, Anne Arundel.

The Executive Board named Janet Kudrna as Treasurer to finish the unexpired term of Mrs Minnick.

The Fun and Profit Auction followed the business meeting. Auctioneer Rita Cobry and Cashier Dorothy Hartel again increased the treasury with money from the hand-made articles. Talents of Maryland medical assistants are indeed hard to duplicate!

A seminar followed with

Dr and Mrs Clarence Vincent, charter members of the Allegany Association for Retarded Children. Dr. Vincent is an internist and cardiologist in private practice in Cumberland. Mrs Vincent is Regional Vice President of the Maryland Association for Retarded Children.

Mrs Vincent, vivacious and sincere in her work for mentally retarded children, stated that institutions are not helpful and that development of the best potential can only be achieved in group homes, with foster parents, or in apartments with co-residents.

"A must in all cases is a definite work schedule," she said, continuing, "It is important to allow the retarded the same rights as others; they must have normalization principles and be sheltered only when absolutely necessary."

She claimed that the best way to really help is to educate the public on the problem and alternate solutions. One of the posters she displayed stated that a turtle is slow but reported that if he sticks his neck out he can make it. It is Mrs Vincent's desire to let the mentally retarded stick out their necks and make it as a productive part of our society.

Dr Jack Harvey, a Cumberland orthopedic surgeon, was the next speaker. His subject: "Total Hip Replacement."

He augmented his talk with a film depicting the entire operation. This operation gives dramatic relief from pain and return to motion.

Dr Jack W Bowerman was the final seminar speaker. He is Assistant Professor of Ra-

diology at Johns Hopkins Hospital. His topic, "Arthrography and Orthopedic Radiology," was illustrated by slides. He followed body X-rays from head to toes, explaining arthrography and its value, especially in the study of rheumatoid disease and synovial cysts.

A banquet followed the seminar. Dr Jack Harvey was Master of Ceremonies. Mr Lamar Minnick gave the invocation.

A candlelight installation service, conducted by Mrs Dorothy Hartel, followed.

A different twist was the reception given by the Men's Auxiliary, a newly organized group of husbands of the medical assistants.

A Sunday morning breakfast, courtesy of the Allegany Chapter, concluded the meeting.

In summary, the Allegany Chapter is highly commended to have hosted such a delightful meeting. This chapter is small in number, but ever so large in effort and hospitality.

RITA COBRY CMA
Publicity Chairman
AAMA — Maryland



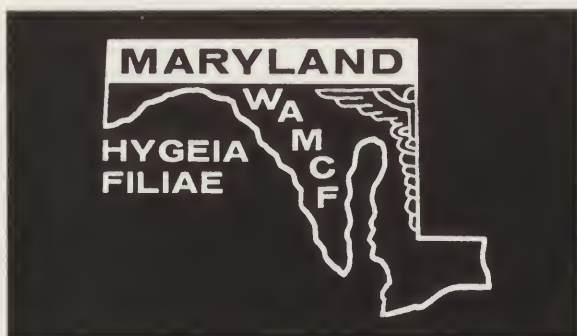
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Dear Doctor: We Are Waiting

More than fifty years ago a movement began which was designed to assist medical societies with their community goals. Over the years, the societies became more involved with the science of medicine and forgot to ask for assistance with community problems related to medicine. Auxiliaries, feeling rejected by the societies, turned to social activities and fund-raising for other community concerns. As a result, medical societies have come to look on auxiliaries as social clubs for the wives.

Today, more than ever, the doctor's wife is not satisfied to participate in clubs which are purely social and limited to women. Most have advanced education or training which prepares them to contribute in a significant way to the community in which they live. Once a doctor is established in a community, there is no longer a need for his wife to continue to work. In most cases she turns to activities where she can use her talents to satisfy her need for adult companionship which most doctors cannot supply because of the demands of their profession.

The private practice of medicine is facing a fight for survival. It will not survive unless all available resources are called upon. The Auxiliary is one untapped resource. Books are being written about the health care crisis. Newspaper and magazine articles point out the problems, but the public has no way to learn the whole picture and predict the results of the many courses of action open to them.

Medicine as a group is silent except for discussing the problems among themselves.

Medical societies must accept the blame if governmental control usurps their rights because they have failed to involve the one group which shares their concern and which has time to help with the dispensing of public information.

It is a rare medical society which would have



a combined meeting with the Auxiliary which was not social in nature. Would one society in the State dare to schedule an exploratory meeting to discuss with the Auxiliary ways in which they could mount a campaign to promote the virtues of the private practice of medicine vs government control?

What are the real issues and problems? What could be done to correct the injustices? What talents are to be found among the members of each Auxiliary? These and dozens more are topics which would fill a series of meetings that could mean the beginning of a new era in medicine in which doctors' wives become partners in this very critical social concern. Every wife should be able to discuss the issues with her

friends outside of medicine when the topic comes up. Yet how many would even have the slightest idea of where to begin?

Senator Edward Kennedy, in his book *In Critical Condition*, sets forth eight questions plaguing medicine and the Senator's idea of the solutions. What a good starting point for mutual discussion. The Auxiliary can not attack such a program by itself. It must have the guidance of the society. How can the doctor be heard if the doctor's wife doesn't even hear him?

Perhaps some counties are already doing this; if so, I would like to hear from them so that their experiences may be shared with others through this column.

The challenge is yours, Dear Doctor.

We are waiting.

MRS FREDERICK MILTENBERGER
Editor

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1821

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1848

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Animal Bites

Dr David R Berzon, Public Health Veterinarian in the Baltimore City Health Department, reports that animal bites have been increasing over the past three years. In 1970, the number of reported bites was 6,415; in 1971 it was 7,313; and in 1972 the number of cases rose to 7,436. Further analysis of animal bites shows a declining trend in the number of children reported bitten. While 60.4% of those bitten in 1970 were under 15 years of age, by 1971 the percentage of this age group bitten had fallen to 56.6%, and by 1972 to 54.2%.

All instances of persons being bitten by any animal in Baltimore City should be reported to the Baltimore City Health Department, phone 396-4433. It is important for the person who was bitten to learn the name and address of the owner so the animal may be kept under observation to be sure it is free from rabies. Stray animals, if possible, should be caught and confined. The animal should never be destroyed. The biting animal should be held in quarantine for a period of at least ten days and examined by a veterinarian. The period of detention and observation can be at the home of the owner of the animal, at a private kennel, or at the Municipal Animal Shelter, 222 N Calverton, phone 396-0218.

Physicians desiring assistance with animal bite cases may call Dr Berzon at the new direct phone number 396-4443.

Public Health Nurses

The City Health Department has announced the establishment of an Advisory Team service to assist public health nurses with problems relating to handicapped children. While at present the service covers the Druid and South-eastern health districts, the service eventually

will be expanded to all five health districts.

The Advisory Team comprises members of both State and City health departments and consists of the following State Health Department members: Dr Edward Hopkins, pediatric consultant; Dr Arnold Capute, pediatric developmental consultant; Edward Crawford PhD, psychology consultant; Miss Ellen Foster and Miss Florence M Burnett, public health nurse consultants; and Mrs Helen Shaw, social service consultant. Also, City Health Department members: Dr Baruni Samal, clinical director, Division for the Handicapped; Mrs June Frisch, senior public health nurse consultant; and Miss Carolyn White, social work consultant.

The aim of the Advisory Team is to help coordinate access to sources of care and to plan such coordination for the multi-handicapped children of Baltimore City. The team meets monthly for discussion of cases presented by public health nurses.

Wash Your Hands Poster

The Baltimore City Health Department has announced the availability of a new poster sticker for use in hospitals, nursing homes, and related institutions. The message of the sticker states in very simple terms DON'T SPREAD GERMS—WASH YOUR HANDS. The stickers are being distributed by sanitarians in the Institutional Inspection Unit of the Bureau of Environmental Hygiene.

Every hospital, nursing home, and other related institution in the City will be visited and given an adequate supply of these reminder stickers to place in kitchens, bathrooms, and other areas where "hand washing" is critical and imperative for all personnel. It is hoped that the stickers will assist in preventing the spread of disease by helping to eliminate one of the main sources of contamination in our institutions.

IT'S NOT TOO LATE TO PLAN TO ATTEND THE 1973 SEMIANNUAL MEETING MEDICAL AND CHIRURGICAL FACULTY MEXICO CITY, SEPT 19-23

Scientific sessions will be held Sept 20, 21, and 22 at the Instituto Nacional de Cardiología. Bus service will be available between the headquarters hotel, El Camino Real, and the Instituto.

The following scientific program will be ACCEPTABLE FOR TEN CREDIT HOURS BY THE AMA PHYSICIAN'S RECOGNITION AWARD, CONTINUING MEDICAL EDUCATION REQUIREMENTS OF THE MARYLAND STATE BOARD OF MEDICAL EXAMINERS, AND ELECTIVE CREDITS BY THE AMERICAN ACADEMY OF FAMILY PHYSICIANS:

THURSDAY, SEPT 20

- 9:00 AM Past, Present and Future of Cardiology in Mexico; Jorge Espino Vela MD; Professor of Clinical Cardiology, and Director of the Instituto Nacional de Cardiología
- 9:35 AM Cardiac Surgery in Children with Rheumatic Heart Disease; Raul Baz MD; Department of Surgery, Instituto Nacional de Cardiología
- 10:10 AM Precordial Movements: Clinical Recognition and Evaluation; Bernardo Fishleder MD; Head of the Department of Phonomechanocardiography, Instituto Nacional de Cardiología
- 11:00 AM Morphologic Organization of the Pulmonary Circulation; Rosario Barroso-Moguel MD; Assistant, Department of Pathology, Instituto Nacional de Cardiología
- 11:35 AM Some Advances in Embryology; María Victoria de la Cruz MD; Head of the Department of Embryology, Instituto Nacional de Cardiología
- 12:10 PM Pitfalls in Renovascular Arterial Hypertension; Herman Villarreal MD; Head of the Department of Nephrology, Instituto Nacional de Cardiología

FRIDAY, SEPT 21

- 9:00 AM Catecholamines and Cardiology; Pedro Serrano MD; Head of the Department of Endocrinology, Instituto Nacional de Cardiología
- 9:35 AM Connective Tissue Diseases: Some Problems of Differential Diagnosis; Javier Robles-Gil MD; Head of the Department of Rheumatology, Instituto Nacional de Cardiología
- 10:10 AM Some Aspects of Myocardial Infarction in Young Adults; Tobias Rotberg MD; Assistant Cardiologist, Clinical Services, Instituto Nacional de Cardiología
- 11:00 AM Cardiac Problems in Relation to Surgery; Ricardo Correa MD; Head of Clinical Cardiology in the Department of Surgery, Instituto Nacional de Cardiología
- 11:35 AM Innocent Murmurs: How to Distinguish them from Pathological Murmurs; Bernardo Fishleder MD; Head of the Department of Phonomechanocardiography, Instituto Nacional de Cardiología
- 12:10 PM Myocardial Infarction in Patients with Artificial Pacemaker; Manuel Cardenas MD; Head of Clinical Ward, Instituto Nacional de Cardiología

SATURDAY, SEPT 22

- 9:00 AM Selective Arteriography and Latrogenic Emboli; Jorge Soni MD; Head of the Department of Haemodynamics, Instituto Nacional de Cardiología
- 9:35 AM Polyparametric Electrocardiography; Demetrio Sodi Pallares MD; Head of the Department of Electrocardiography, Instituto Nacional de Cardiología
- 10:10 AM Arteritis in Children; Jorge Espino Vela MD; Director, Instituto Nacional de Cardiología

ACTIVITIES SCHEDULE—SEMIANNUAL MEETING

SEPT 15

BUSINESS MEETINGS, Faculty Bldg, 1211 Cathedral St, Baltimore

SEPT 19

Depart in the AM from Friendship Airport via American Airlines to Mexico City, capital of Mexico. Upon arrival, convention members will be met at the airport and bussed to EL CAMINO REAL, a luxury retreat of contemporary Mexican architecture that is totally unique, with lush gardens, sparkling fountains, landscaped walkways for strolling, and exquisitely appointed accommodations, each with private bath. Baggage will be brought to the hotel and placed in your room.

After the DAILY SCIENTIFIC SESSIONS, every luxury and activity one could possibly desire is available at the hotel for between-meeting relaxation . . . four swimming pools . . . tennis courts . . . a putting green . . . night spots . . . bars . . . and "Cero Cero," the wildest discotheque either side of the border.

Nearby is the famous Chapultepec Park and the fun and excitement of Mexico City, one of the world's really great places. Shopping in Mexico is a joy . . . an adventure that is unmatched almost anywhere else. And, of course, there will be Optional Sightseeing Tours of the many fascinating sights and remains of ancient cultures in and around Mexico City. A "must" is the world famous National Museum of Anthropology, where the famed Aztec Calendar Stone is among the treasures.

SEPT 20 - 22

Daily scientific sessions at the Instituto Nacional de Cardiologia

SEPT 19 - 23

During the Semiannual Meeting, INCLUDED are:

Full multi-course American breakfast each morning at El Camino Real
Welcome Cocktail Party

Dinner each evening, including two on a "Dine Around Basis" allowing you to choose from a long list of outstanding restaurants.

Gala Farewell Party — cocktails, dinner, dancing, and lavish entertainment in the beautiful ballroom of El Camino Real — a grand finale to the 1973 Semiannual Meeting.

SEPT 23

Convention members and baggage will be transferred from the hotel to the airport for the return jet charter flight to Baltimore.

SEPT 23 - 29

Postconvention Tour to Acapulco. Headquarters: the new Acapulco Princess and Club de Golf, superbly located directly on the Pacific Ocean, surrounded by magnificent landscaping. Full information on this tour has been mailed to all Faculty members with the official program for the Semiannual Meeting. If you have not received a copy, call the Faculty office 301-539-0872.

JAMES D DRINKARD MD, Chairman
Committee on Program and Arrangements

**RESERVATION FORM FOR MED-CHI
1973 SEMIANNUAL MEETING**

Send to:

Committee on Program and Arrangements, Medical and Chirurgical Faculty,
1211 Cathedral St, Baltimore Maryland 21201

I would like to make a reservation for the MED-CHI SEMIANNUAL MEETING in Mexico City, Sept 19 to 23, 1973. Enclosed is payment in full in the amount of \$.....(\$286 per person, made payable to TRAVEL GUIDE AGENCY LTD) for #.....reservations. Monies paid are refundable subject to resale of reservation(s).

MEXICO CITY SEMIANNUAL MEETING — \$269 per person (based on double occupancy)

Plus \$17 — tax and service

() Single room desired at a supplemental rate of \$35

() Please send me information and reservation form on the Postconvention Tour to Acapulco — Sept 23 to 29.

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CITY

STATE

ZIP CODE

(home)

PHONE

(office)

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ANNUAL REPORTS TO THE HOUSE OF DELEGATES



HOUSE OF DELEGATES IN SESSION APRIL 25, 1973

The following committees or groups held no meetings during the year:

- Contractual Arrangements
- Maryland State School Health
- Medical Annals of Maryland
- Policy and Planning
- Student American Medical Association
- Medical Emergency Disaster Service
- Professional Medical Services

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BOARD OF MEDICAL EXAMINERS

Mr President and Members of the House of Delegates:

The Board of Medical Examiners of Maryland is composed of the following members whose terms expire on the dates indicated below:

John E Adams MD	1973
Archie R Cohen MD	1976*
DeWitt E DeLawter MD	1973
Gerald A Galvin MD	1975
J Roy Guyther MD	1975
Elmer G Linhardt MD	1974
Karl F Mech MD	1976
John F Schaefer MD	1974

* Deceased 3/6/73

Examinations given during the year show the following results:

Applications received for examination	514
Postponed, withdrawn, or did not appear	50
Not eligible for license	25
Complete examination	439
Reexamined	130
Eligible for license	267
Passed—American Graduates	82
Passed—Foreign Graduates	185
Failed—American Graduates	9
Failed—Foreign Graduates	163
Licenses issued after examination	267
Licenses issued by endorsement of National Board Certificate	442
Licenses issued by reciprocity with other state licenses	294
Total licenses issued	1,003
Licenses revoked	1
Licenses suspended	0
Licentiates certified to other states	444
Copies of licenses issued	14
Foreign graduates approved for examination	398
Written inquiries from foreign graduates (approx)	2,500
Office interviews with foreign graduates (approx)	1,000
Telephone inquiries from foreign graduates (approx)	3,000
Telephone inquiries re-registration of physicians	6,500
Registration Certificates issued from 1/1/72 to 12/31/72	11,162

Maryland Society of Pathologists

The Maryland Society of Pathologists requested approval for the relaxation of the present rules with respect to advertising. Dr Paul Guerin was present and represented the Maryland Society of Pathologists. The situation was discussed thoroughly by the Board. At the conclusion of the meeting the Board recommended that the Maryland Society of Pathologists be notified as follows:

"The Board of Medical Examiners of Maryland, at its meeting on Thursday, Jan 27, 1972, reviewed the material relating to the request for relaxation of the restrictions on advertising by the pathologists of the State of Maryland. It was the decision of the Board that you be informed of the fact that this request be denied."

Preceptorship Programs

Dr Mech presented the basic format for the development of a preceptorship program as recommended by the Executive Committee of the Maryland State Board of Medical Examiners. On February 17, 1972 the Executive Committee met with the Professional Practice Committee of the Maryland Hospital Association. There was considerable discussion relating to the use of unlicensed physicians in the State of Maryland and the problems as-

sociated with compliance with the rules and regulations relating to Section 122 "Practice Without a License." It was suggested that perhaps approval could be obtained under the category of preceptorships. It was also suggested by the Executive Committee that a format outlining the preceptorship program at each individual hospital involved, be forwarded to this Board. It was generally agreed that, at this point in time, any such proposed program would be more or less a stop-gap measure. The Professional Practice Committee of the Maryland Hospital Association was advised that any hospital anticipating the utilization of a preceptorship program be advised to submit a format to the Board. It was suggested that a) a definite cut-off date be considered, or b) that a point in time be established for reevaluation of all approved preceptorship programs.

The physicians concerned should be eligible to sit for the examination at the time of their acceptance or become eligible during the time that he is involved in the program.

In summary, the above requirements should be made a prerequisite for those hospitals requesting approval of their preceptorship programs.

The preceptorship formats were presented by the following hospitals:

North Charles General Hospital
Washington Sanitarium
Baltimore City Hospital
Deer's Head State Hospital
Baltimore County General
St Joseph's Hospital
Lutheran Hospital
Franklin Square Hospital
St Agnes Hospital
Church Home and Hospital

After a careful review and discussion of the proposed preceptorship programs, as submitted by the above hospitals, it was the decision of the Board of Medical Examiners of Maryland to notify the hospitals concerned as follows:

A formal meeting of the Board of Medical Examiners of the State of Maryland was held on April 27, 1972 and the problem of the unlicensed physician was discussed in detail.

The following principles and guidelines were formulated and are listed below for your information and implementation:

- 1) The preceptee must be qualified to sit for the State Board examination in the State of Maryland.
- 2) It must be the intent of the preceptee to sit for the State Board examination within two years of the beginning of the preceptorship.
- 3) The preceptee must confine his professional activities to those related to the hospital preceptorship program and shall not engage in private practice or cover the office practice of staff physicians outside the hospital.
- 4) The preceptorship program must provide an adequate training program for the preceptee, and the program must be submitted to and approved by the Board of Medical Examiners of the State of Maryland.
- 5) The program for each preceptee shall be reviewed yearly by the Board of Medical Examiners of the State of Maryland and shall not exceed a total period of two years.
- 6) There shall be one preceptee for each 75 beds and one preceptor per preceptee.

- 7) No person shall serve as a preceptee in the State of Maryland for a period in excess of two years.
- 8) No exception shall be made to the above rules, except by the authority of the Maryland State Board of Medical Examiners.

Will you please revise your outlines submitted to us to conform to the principles and guidelines given and return to this Board so that they may be reviewed and an early decision rendered.

The following principles and guidelines were formulated and revised June 1, 1972:

- 1) The preceptee must be qualified to sit for the State Board Examination in the State of Maryland.
- 2) It must be the intent of the preceptee to sit for the State Board Examination within two years of the beginning of the preceptorship.
- 3) The preceptee must confine his professional activities to those related to the hospital preceptorship program and shall not engage in private practice or cover the office practice of staff physicians outside of the hospital.
- 4) The preceptorship program must provide an adequate training program for the preceptee, and the program must be submitted to and approved by the Board of Medical Examiners of the State of Maryland.
- 5) The program for each preceptee shall be reviewed yearly by the Board of Medical Examiners of the State of Maryland and shall not exceed a total of two years.
- 6) Each preceptee shall be responsible for no more than 25 beds and there shall be one preceptor per preceptee.
- 7) No person shall serve as a preceptee in the State of Maryland for a period in excess of two years.
- 8) No exception shall be made to the above rules, except by the authority of the Maryland State Board of Medical Examiners.

Preceptorship programs in the following hospitals were reviewed and approved.

North Charles General Hospital
 Washington Sanitarium and Hospital
 Baltimore City Hospital
 Deer's Head State Hospital
 Baltimore County General
 St Joseph's Hospital
 Lutheran Hospital of Maryland
 Franklin Square Hospital
 St Agnes Hospital
 Church Home & Hospital
 Holy Cross Hospital of Silver Spring
 South Baltimore General Hospital
 Peninsula General Hospital
 St Mary's Hospital
 Provident Hospital
 Johns Hopkins Hospital

Change in Rules Regarding the Foreign Medical Graduate

A new pathway for graduate training is available for the foreign medical graduate who is not a United States National. This American who, despite constant and significant expansion of our medical school enrollments, failed to gain admission to a United States school, attended a foreign medical school. A program is available that requires sponsorship of the student by an approved United States medical school for a year of supervised clinical training. The student must also have a premedical record which would have qualified him for admission to

an American medical school and must pass a screening examination to assure that he is qualified for clinical training. After completion of that year, the student is eligible for participation in an approved program of graduate medical education. Furthermore, it is recommended that licensing bodies consider the individual on the same level you would consider the graduate of a United States medical school after he has satisfactorily completed his year of clinical training.

Family Health Advocate

The job description, qualifications, of the Family Health Advocate — Johns Hopkins Hospital, were reviewed in detail. At the conclusion of the discussion it was the decision of the Board that those duties outlined would be in violation of the Medical Practice Act. The following were to be notified:

The Hospital Administrator — John Hopkins Hospital
 Medical and Chirurgical Faculty of the State of Maryland

Department of Employment Security

The above were notified as follows:

"Your attention is directed to the enclosed copy of the Employer's Job Title — Family Health Advocate, Job Location Johns Hopkins Hospital. After careful review of the material relating to Family Health Advocate, it is the opinion of the Board of Medical Examiners of the State of Maryland that these individuals performing under the title "Family Health Advocate," would be in violation of the Medical Practice Act.

Continuing Education

John F Schaefer MD moved that the Board accept the proposed continuing medical education requirements and to promulgate the regulations for continuing medical education:

I. For the purpose of protecting the health and well-being of the citizens of this state and maintaining and continuing informed professional knowledge and awareness, the Board may establish mandatory continuing education requirements for physicians licensed in the state. In establishing such requirements, the Board shall recognize and give weight to existing educational methods, procedures, devices, and programs in use among the various medical specialties and other recognized medical groups and the consensus of the members of the medical community. This subsection does not abrogate or affect the status, force, or operation of the Medical Practice Act.

II. Proposed Regulations for Continuing Medical Education

- 1) The Maryland State Board of Medical Examiners requires 150 hours of continuing education every three years. These may be distributed over the three-year period or they may all be obtained in one year.
- 2) The Board will accept the Physicians Recognition Award of the American Medical Association and the Certificate of Continuing Education of the American Academy of Family Physicians and will also consider approval of programs of other organizations as they are developed.
- 3) In case licensees fail to meet the requirements because of illness or other extenuating circumstances each case will be considered by the Board on an individual basis and when circumstances justify it, may grant an extension of time.
- 4) Types of Credits allowed:

- I. Required education — 30 hours
 - II. Elective category
- At least 30 of the 150 hours must be in required education.

DEFINITIONS

A credit hour is on the basis of one clock hour of participation in a continuing education activity.

REQUIRED EDUCATION

- Category 1: Internship, residency or fellowship; 50 credit hours per year during service in AMA approved programs for training.
- Category 2: Education for an advanced degree in a medical field or medically related field. Fifty credit hours are allowed for each full academic year of study.
- Category 3: Research in lieu of training. Credit is given only for full-time research. Fifty hours for each full year of research.
- Category 4: Continuing education or postgraduate courses. A course is considered to be a series of educational procedures that are planned, coordinated, and organized to meet specific educational objectives for a defined group of physicians. Courses offered by any organization or institution listed as a course sponsor or cosponsor in "Continuing Education Courses for Physicians," *Journal of the American Medical Association*, are creditable. (Physicians Recognition Award) The average practicing physician will fulfill most of his required education in this category.
- Category 5: Teaching: One credit hour is allowed for each clock hour of teaching of medical students or physicians in an approved medical school or approved internship or residency program, not to exceed 90 hours.
- Category 6: Papers or Publications: Ten hours may be claimed for each medical scientific paper or publication. A paper must be presented to a recognized international, national, regional, or state medical society, or other medical organization. A publication must appear in a regular recognized medical or medically related scientific journal. Scientific material used in the paper or publication may be credited only once.

ELECTIVE EDUCATION

Attendance at hospital staff meetings, city or county society meetings, regional, national or international scientific meetings or journal clubs — one hour credit for each hour of attendance.

PROCEDURES

- 1) The Secretary will provide a form for the listing and documentation of claimed credits for continuing medical education with the application for reregistration.
- 2) When the statements are returned to the Secretary of the Board, he will check them and the credits allowed the licensee will be placed on record for future references.
- 3) The end of the first three-year period will be September 1976.

TEMPORARY PERMIT TO PRACTICE MEDICINE

The Board approved temporary permits to practice medicine for one year to Karim Vessal MD, Edmond Antony Murphy MD, Lars G A Belin MD, David Brandes MD, and the following letter was sent to the above named doctors:

"Pursuant to your request for a temporary permit to practice medicine in the State of Maryland, the Board of Medical Examiners on June 1, 1972 approved your request. Upon receipt in this office of the required fee of \$25.00 a certificate will be issued to you."

DECLARATION OF INTENTION

The current rules for licensure of the Board of Medical Examiners of the State of Maryland require that an applicant present a Declaration of Intention as one of the preliminary requirements for application for licensure. It is the Board's desire to amend these regulations in order that a Declaration of Intention will no longer be required.

MODIFICATION OF DECLARATION OF INTENTION

On Dec 28, 1972 the Board expressed its approval that the requirement of Declaration of Intention issued by the Immigration Department no longer is necessary. The Board will accept a letter indicating the applicant's intent to obtain a Declaration of Intention.

MODIFICATION OF DECLARATION OF INTENTION—PRECEPTORSHIP PROGRAMS

It was suggested that the following letter be sent to all hospitals:

"The Board expressed its approval that the requirement of Declaration of Intention issued by the Immigration Department, no longer is necessary. The Board will accept a letter indicating the applicant's intent to obtain a Declaration of Intention. In accordance with the above, preceptorship programs will be phased out as of July 1975."

ACUPUNCTURE

The following letter was sent to Mr John Sargeant, Medical and Chirurgical Faculty, with copies to the New York State Board for Medicine and the Iowa State Board of Medical Examiners:

"It is the Board's decision that acupuncture is the practice of medicine since acupuncture has been used for three primary purposes: 1) for anesthesia for certain surgical procedures in medicine and dentistry, 2) for the relief of chronic pain, and 3) for the modification of organ function. Some information already is being accumulated on the first two of these uses, but very little is known of the effects, either intended or unintended (side effects), of acupuncture on modification of organ function. Since acupuncture is investigational at this time, it is urged that it be used by physicians only at medical research institutions."

Respectfully submitted,

ELMER G LINHARDT MD, Executive Secretary

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BYLAWS COMMITTEE

Mr President and Members of the House of Delegates:

Your Bylaws Committee met on Jan 31, 1973 to consider various matters referred to it since the Semiannual Meeting in 1972.

Membership of Interns and Residents on Full, Active Basis

For some time, there has been concern expressed over the desirability of permitting the above categories of physicians to become Active members of the Faculty, thus enabling them to hold office, to vote, and have all the other rights and privileges of full, Active membership.

After considerable discussion, the Bylaws Committee is of the opinion that physicians in such categories should be permitted to have Active membership, provided they pay full, Active dues and provided the local component approves. In order to accomplish this, the following Bylaws amendment is offered:

1. Amend Article II (Membership) Section 2(b) after "(2)" and before "and (5)" by inserting "(3)".

This amendment will give such individuals the right to opt whether they wish to be Associate or Active members. This option is available already to those persons who are:

- 1) Doctors of Medicine who are not engaged in the full-time practice of medicine
- 2) Doctors of Medicine engaged in the practice of medicine and in full-time positions in a medical school, having a rank below that of associate professor
- 3) Commissioned medical officers of the armed forces, public health service, and Veterans Administration

The Bylaws Committee also considered the question of having a separate section composed of interns and residents, which section would be considered a component of the Faculty. It was deemed advisable not to recommend such action at this time, but rather provide for full, active membership of interns and residents through component medical societies which so determine that this is acceptable.

The Bylaws Committee was also asked to give consideration to the problem of physicians not holding Maryland licenses, but practicing with governmental groups in Maryland, and living nearby in a contiguous state. The Committee was of the opinion that such individuals could presently apply for membership and that no bylaw change to provide an exception specifically for such persons should be made.

Dues for Associate Members Through Baltimore City Dental Society; Dues Structure for Associate Membership

The Bylaws Committee considered the present dues structure for Associate membership in the Faculty. At present, there is a gradation of dues for such Associate membership depending on the category. It currently varies from \$5.00 to \$25.00.

It was the consensus of the Bylaws Committee that this should be a standard fee for all Associate members of \$25.00.

The Committee also considered an agreement reached with the Baltimore City Dental Society for an annually negotiated payment, rather than the present dues of \$5.00 per year per member. This would enable sums received to adequately cover the services provided. The Treasurer has negotiated the following figures for the years shown:

1973	\$1,950
1974	\$2,250
1975	\$2,500

Dues received in 1972 under the current system were \$1,745.00.

The following Bylaws amendment is offered to accomplish these objectives:

2. Amend Article III (Finance) Section 1(b) by substituting for it the following:

"(b) FOR ASSOCIATE MEMBERS: \$25.00 provided however that for those described in Article II, Section 2 (7) the dues shall be negotiated annually for all members of the Baltimore City Dental Society on a group basis."

Change in Charge to Occupational Health Committee

The Faculty's present Occupational and Environmental Health Committee has recommended that its charge and title be changed to read as follows:

3. Amend Article XI, Section 18 by substituting for it the following:

"Section 18. AN OCCUPATIONAL HEALTH COMMITTEE of at least five members shall study and report as it deems advisable upon all phases of occupational health including the working environment. It shall consider such subjects as occupational health problems in industry; and the quality and health environment in industry, as it affects the working man. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President."

The areas of activity deleted from the present Bylaws are now a concern of the Committee on Preventive Medicine and Public Health through its various subcommittees, such as the Subcommittee on Human Ecology and the Subcommittee on Traffic Safety. Your Committee recommends this change be approved.

OTHER DISCUSSIONS

The Bylaws Committee gave consideration to several other items before it. These included:

Tenure of AMA Delegates

At present AMA Delegates and Alternates are elected for three-year terms. The American Medical Association has requested state medical organizations to consider placing a limit on the number of terms that delegates can serve. The Bylaws Committee felt the present system of election enabled flexibility in selecting those best able to carry the feelings and direction of the Faculty to AMA sessions. No change to limit the number of terms such Delegates and Alternates can serve is recommended at this time.

Approval of Scientific Sessions

The Committee on Continuing Medical Education recommended to the Bylaws Committee that an appropriate committee of the Faculty be charged with supervision or approval of all scientific programs given so as to ensure that quality programs are presented and that no duplication exists.

At present, funding of all such programs is vested with the Executive Committee and Council which provides for assurance that an evaluation of the program takes place. In addition, committee and subcommittee sponsorship of such programs does much to ensure quality simply because of the enthusiasm, interest, and expertise the individual members have in assuring the program's success.

Your Bylaws Committee has no recommendation for changes in these two areas at this time.

Respectfully submitted,

CHARLES F O'DONNELL MD, Chairman
VINCENT I FIOCCO MD
JOHN F SCHAEFER MD
WILLIAM G SPEED III MD

COMPARISON OF PROPOSED CHANGES, BYLAWS, FOR CONSIDERATION APRIL 25, 1973

Amend Article II (Membership) Section 2 (b) after "(2)" and before "and (5)" by inserting "(3)".

OLD

Those Doctors of Medicine in Section 2 (a) (1), (2) and (5) may elect to become Active members rather than Associate members, if the component society approves and active dues and assessments are paid.

NEW

Those Doctors of Medicine in Section 2 (a) (1), (2), (3) and (5) may elect to become Active members rather than Associate members, if the component society approves and active dues and assessments are paid.

Amend Article III (Finance) Section 1 (b) by substituting for it the following:

OLD

(b) FOR ASSOCIATE MEMBERS: \$25.00 for those described in Article II, Section 2 (1) (2) and (5); \$10.00 for those described in Article II, Section 2 (3) and (4); and \$5.00 for those described in Article II, Section 2 (6) and (7).

NEW

(b) FOR ASSOCIATE MEMBERS: \$25.00 provided however, that for those described in Article II, Section 2 (7) the dues shall be negotiated annually for all members of the Baltimore City Dental Society on a group basis.

Amend Article XI, Section 18 by substituting for it the following:

OLD

Section 18. AN OCCUPATIONAL AND ENVIRONMENTAL HEALTH COMMITTEE of at least five members shall study and report as it deems advisable upon occupational and environmental health matters. It shall consider such subjects as occupational health problems in industry; consumer protection matters such as food, drugs, etc.; hazardous substances, such as poisons, toys, devices, etc.; the quality of the health environment such as water and air pollution and land use, etc.; as well as traffic safety, such as warning devices, highway signs, automobile construction, accident evacuation, first aid training, etc.

Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.

NEW

Section 18. AN OCCUPATIONAL HEALTH COMMITTEE of at least five members shall study and report as it deems advisable upon all phases of occupational health including the working environment. It shall consider such subjects as occupational health problems in industry; and the quality and health environment in industry, as it affects the working man. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.

CONTINUING MEDICAL EDUCATION COMMITTEE

Mr President and Members of the House of Delegates:

In the spring of 1971, at the annual meeting, the House of Delegates approved a modification of the Bylaws of the Medical and Chirurgical Faculty which established the Committee on Medical Education. The charge, as set forth in the bylaws: The Continuing Education Committee shall consider and advise on postgraduate education programs, all phases of medical education, including hospital education programs, such as residency training programs. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty."

The first meeting of the committee was held, under the chairmanship of Gerard Church MD, on Nov 12, 1971. It was decided that the committee would have three main initial efforts.

Accreditation of Med-Chi

First, the committee attempted to secure accreditation for the Faculty as an organization to award the highest approved credits for the Physician's Recognition Award of the American Medical Association. To receive this accreditation it was necessary that a survey be performed of the educational activities of the Faculty by the AMA. This survey was performed at the annual meeting in the spring of 1972. The Medical Education Council of the AMA notified the Faculty that it was an accredited association in September 1972.

Educational Resource

The second thrust of the committee was to serve as an educational resource for physicians and Allied Health professionals within the State of Maryland. This had been effected by judicious appointments of representatives of the Board of Medical Examiners, the Educational and Organizational components of the American Academy of Family Physicians, federal programs which had continuing education components, directors of education and community hospitals, and physician educators who had involved themselves in the education and utilization of Allied Health professionals. Those disciplines represented on the Continuing Education Committee as an education resource were Internal Medicine, General Surgery, Pediatrics, General Practice, Gastroenterology, and Cardiology.

Local Accreditation

The third thrust was to establish as a local "Out-reach" effort of the AMA accreditation methodologies for physicians' recognition work of local organizations, institutions, and/or associations located primarily within the State of Maryland. A subcommittee was appointed under chairmanship of Dr Henry Herbert. This subcommittee consisted of Drs Herbert, Meade, Linhardt, and Smoot. In the spring of 1972 this subcommittee submitted to the Continuing Education Committee the necessary documents for implementation of the accreditation process for the physician's recognition award.

The Continuing Education Committee and Council of the Faculty approved the documents and methods of implementation and submitted them to the AMA for approval.

In September 1972, the Council on Medical Education of the AMA approved the documents and methodologies as submitted.

The accreditation process as performed by the Faculty at the present time has two forms.

- 1) Institutional, Organizational, and/or Association Accreditation
- 2) Short Course Accreditation

It should be clearly understood that in this effort the Medical and Chirurgical Faculty is a "Vendor" for accreditation of courses for the Physician's Recognition Award of the AMA and those educational activities located in Maryland having a primary impact upon Maryland physicians and Allied Health Professionals.

Institutional, Organizational, and/or Association Accreditation

A presurvey questionnaire was carefully designed to provide the committee with a picture of the institution's continuing medical education activities. The completed questionnaire was submitted to the subcommittee on accreditation and a survey team was selected. The date of the survey site visit was always at a time when the applicant was having continuing education activities. The survey team consisted of three members: two from the Continuing Education Committee and one from the component medical society where the institution, organization, and/or association was located.

The State of Maryland accreditation activity stands unique in requiring component medical society participation. We feel that this is essential in order to encourage the institutions to reach out beyond the educational requirements of their own staffs and to identify and provide for educational needs within communities they serve.

Upon completion of the survey the recommendations were submitted to the Continuing Education Committee. If approved, the committee submitted the recommendations to the AMA for ratification. If the application was disapproved, the applicant was notified. Appeal process is available by direct appeal to the Council of the Medical and Chirurgical Faculty for all decisions of the Continuing Education Committee.

To date, the subcommittee has surveyed two Maryland institutions. Surveys of six others are pending.

Short Course Accreditation

The committee felt that there should be a process of accreditation available for individual departments and/or educational efforts within an institution association and/or organization of particular excellence where the parent institution, organization, or association was not accredited. It was also felt that there would not always be a broad-based capability and/or potential for some institutions to receive the larger survey.

Therefore, the subcommittee designed the short-form, "Short Course" accreditation process, designed primarily to give accreditation for short courses, 20 hours or less per year, which demonstrated excellence and relevance to Maryland physicians. Applicants request a short form and submit it to the subcommittee for its approval.

To date, we have approved over 100 hours of short-course activity for the Physician's Recognition Award. It is our feeling that this educational activity will evolve into eventual institutional, organizational and/or association accreditation.

Only by high-quality, relevant educational activities for demonstrated needs, subject to periodic quality control efforts, can the practitioner remain truly "up-to-date."

Respectfully submitted,

GERARD CHURCH MD, Chairman
HENRY R HERBERT JR MD
PHILIP W HEUMAN MD
ELMER G LINHARDT MD
JOSEPH A MEAD MD
ROBERT R MONTGOMERY MD
ROLAND T SMOOT MD
JACK M ZIMMERMAN MD

COUNCIL AND EXECUTIVE COMMITTEE

Mr President and Members of the House of Delegates:

As has been the custom in the past, a summary of all actions of the Executive Committee and Council has been made available to all members through the *Maryland State Medical Journal*. In addition, copies of the minutes of all of these meetings have been distributed to those component medical societies wishing to receive them.

Individual members of the Council have, in all instances, been urged to report back to those component medical societies within their councilmanic districts what actions the Council is contemplating and has taken.

It is by these efforts that we attempt to let the individual members know what is taking place at the state level.

Many routine items were discussed and action taken on them during the past year. Appointments have been made and recommendations made for appointments where the Faculty does not directly designate the persons to serve. As always, there is sometimes a paucity of persons willing to serve on behalf of the Faculty. Should you have special interests or feel you have special talents to offer on behalf of your fellow-members, please let us know.

Among the more important matters considered and acted upon by the Council during the year were the following:

- 1) Approval of the concept that certain immunizations be required of school children prior to entering school
- 2) Proposed immunization of persons at "high risk" for smallpox
- 3) Employment of a PR Consultant on a one-year trial basis, the costs to come from Educational Fund monies
- 4) Institution of a membership campaign dealing with nonmembers of the Faculty and nonmembers of AMA
- 5) Adoption of the 1973 budget for Faculty operation. At this meeting, each component society was invited to send a representative to hear the budget discussion and ask any questions they might have. Five component societies were represented at this session.

The Council recommends to the House of Delegates that Emeritus Membership be granted to the following members of the component society indicated:

Anne Arundel County Medical Society:
Robert R Hahn MD, Severna Park

Baltimore City Medical Society:
William C Dunnigan MD, Baltimore
F A Pacienza MD, Baltimore
Harry N Rudin MD, Baltimore
William Schuman MD, Baltimore

Carroll County Medical Society:
Robert S McVaugh MD, Taneytown

Howard County Medical Society:
Theodore R Shrop MD, Ellicott City

Montgomery County Medical Society:
Henry W Jaeger MD, Silver Spring

Talbot County Medical Society:
Shepard Krech Jr MD, Easton

Washington County Medical Society:
M C Smoot MD, Hagerstown

Affiliate:
Lester W Harris MD, Ocean City

The Council also recommends adoption of the following resolution by the House of Delegates:

Resolved, That the membership of this society be informed that the Medical and Chirurgical Faculty has taken no official stand to date on PSRO as embodied in HR1 (the Bennett amendment); and

Resolved, That in the ensuing months every effort of our society and its members be expended to acquaint themselves with the law and its (as yet unpublished) regulations so that an informed decision may be made at the appropriate time.

Respectfully submitted,

MANNING W ALDEN MD, Chairman

CURATOR

Mr President and Members of the House of Delegates:

As has been the custom for many years, the work on restoration of portraits continues on an annual basis with as many restorations as possible, within budgetary limitations, being carried out each year. Costs in this area, as in all areas, have increased tremendously and it is becoming exceedingly difficult to operate within the allotment made by the House.

We have received a copy of all catalog cards prepared by the Smithsonian Institution for those artifacts that have been loaned for an indefinite period. Several displays of some of this material have been developed by the Smithsonian and presented to the public with appropriate recognition being given to us.

During the past year, many gifts have been made to the Faculty to add to our collection. We are grateful for the following gifts, which have been duly acknowledged:

Sundry books and medical material from the Estate of Clara New Rosenheim, widow of the late Sylvin Rosenheim MD.

The following items from Mrs Thrisler Pentz, widow of William F Pentz Jr MD:

Leather bound pocket dictionary

Washington University material:

Diploma of graduation from William F Pentz Jr
Commencement invitation 1873 and 1874
Statement of matriculation from William F Pentz Jr
Admission cards to anatomy and obsteric classes

Two newspaper clippings

One print of Christopher Johnson MD

One forceps

A generous collection of journals, books, and pictures from Mrs Edward H Richardson's husband's library.

A collection of 11 books dating from 1816 to 1939, the earliest being Adolphus Murray's, a description of the arteries of the human body (1816), from John B De Hoff MD.

A humorous volume of personal experiences of Dr Maurice Chideckel, from Samuel S Glick MD.

It is a pleasure to be associated with the Faculty as its Curator. Our collection contains some of the most important items representing the history of medicine in the United States. We should be proud to be associated with this history.

Respectfully submitted,

E DAVID WEINBERG MD, Curator

DELEGATES TO THE AMA HOUSE OF DELEGATES Nov 26-29, 1972 CINCINNATI, OHIO

Mr President and Members of the House of Delegates:

The Faculty's Delegates to the AMA House of Delegates journeyed to Cincinnati, Ohio for the 26th clinical convention of the AMA, Nov 26-29, 1972. In addition, two of the alternate delegates, as well as the Faculty president, also attended. Two staff members assisted the Maryland delegation in fulfilling its responsibilities during the meeting.

The following summary of highlights of the meeting is provided for information of Faculty members:

PSROs

The AMA will "provide a dominant role of leadership in the implementation of the PSRO program to assure that the best interests of the public and the profession are preserved," the House decreed, in adopting Report Z of the Board of Trustees and the Council on Medical Service. The issue of PSRO — Peer Standards Review Organization — was #1 at the convention.

A lengthy plea by one delegate that the House defer action on Report Z — which he called a "complete reversal of our policy" — was rejected. Report Z noted that while PSRO legislation was pending in Congress, the AMA questioned whether its emphasis on cost control might not lead to a lowering of the quality of medical care. But since it is now law, the report said, AMA should act to guard the interests of the public and the profession.

An AMA Advisory Committee on Professional Standards Review will be created by the Board of Trustees. It will include members of the Board and Council on Medical Service. In addition, the Board may invite other appropriate organizations to participate.

Among responsibilities of the Committee are these:

- 1) To provide input from the medical profession in the development of rules and regulations which will govern the PSRO program.
- 2) To assist state medical associations, or state medical associations in concert with county societies, in developing PSROs and to recommend structures and operating mechanisms for such organizations.
- 3) To aid in defining appropriate geographic boundaries for PSROs, especially where more than one state may be involved.

In addition to the eight areas of responsibility outlined in Report Z (including the above) floor amendments added several more which would have the Committee:

Develop and distribute information about PL 92-603 to constituent societies; monitor the effect of PSRO on medical care, and report to each future House session; and instruct the House and state societies on procedures to follow "whenever rules and regulations interpreting the law and published in the Federal Register seem to be contrary to the spirit of the law as written."

President's Address

Carl A Hoffman MD, President, offered bold suggestions as to how some long-decried national health problems might be solved.

The major problems, he said, are protecting Americans from financial ruin due to catastrophic illness, and the maldistribution of physicians as it affects the inner city and rural areas.

Dr Hoffman, in reporting on his recent European survey of health care systems, showed a film of his interviews in England, Sweden, West Germany, and the Soviet Union.

"What impressed me most," he said, "was the fact that the health care problems of the United States also are to be found in these other nations — where economic, political, and cultural conditions are so different from our own."

The nations he visited also grapple with maldistribution, which limits access to medical care for some citizens.

"But we in the United States appear to be sadly deficient in insurance coverage for catastrophic illness," the AMA president said. "No one in this affluent nation should suffer financial deprivation or bankruptcy because of serious illness or accident."

The Huntington, WV urologist said insurance company executives had told him there were "insoluble problems" involved in providing such coverage. "But I have a suggestion which may help solve one of those problems, that of abuse.

"I suggest that a number of conditions be specified as catastrophic — hemophilia, stroke, severe burns, and severe injuries, for instance."

Perhaps certain stipulations could be made to provide coverage for unforeseen or extremely unusual situations, he said, adding:

"A precedent has been established by HR 1, which recently became law and provides financial protection for those undergoing renal dialysis.

"I cannot believe that this proposal is not workable."

As for maldistribution of doctors, Dr Hoffman offered what he called "perhaps a revolutionary suggestion" on how to get physicians into rural areas: A "strictly voluntary" program under which needy students could get a medical education with state or federal financing, by signing an unbreakable contract to practice in needy areas for three or four years. He would have no option to repay the loan in cash.

To control the program, medical societies and licensing boards could grant temporary licenses, allowing the physician to practice only in the designated community. After the period of service was completed, the physician would get complete licensure.

In regard to doctor shortages in the inner cities, Dr Hoffman said, "It is possible that part of the solution may lie in neighborhood health centers."

His proposals were referred to the Council on Medical Service.

Budget and Fiscal Restraint

A summary of the 1973 AMA budget, prepared by the Office of Finance and the Finance Committee, drew congratulations from the reference committee which studied it. And budget-cutting action recently taken by the Board of Trustees was approved by the House.

"In considering the budget for 1973, the Board of Trustees made a determined effort to exercise fiscal restraint, and to allocate our financial resources according to priority needs," the Board said in Report A. The budget summary anticipates 1973 gross revenues of just over \$37 million and operating expenses of \$36,322,000, leaving a projected surplus of about \$800,000.

Fiscal restraint action taken by the Board included the termination of four councils and six committees. One resolution sought to rescind termination of the Council on Drugs, but the House instead adopted a substitute

resolution. That measure says the Board shall continue to use "all appropriate AMA resources and methods indicated, to the point of establishing a committee, if necessary, to delineate clearly the independent AMA policy on drugs and drug therapy."

Another economy action was making specialty journals available on subscription only, starting January 9. *Prism*, the AMA's new socioeconomic publication, will be sent as a membership benefit, along with JAMA.

Medical Care of the Poor

Since the House in 1971 urged creation of state and local medical society committees concerned with health care of the poor, 23 state and 29 local societies have set up such panels. And they are now developing programs to improve health care services. This progress note is included in Report G of the Council on Medical Service, which the House urged be given wide distribution. The report emphasized that local systems must be developed to meet local needs.

On related measures, the House urged organized medicine to continue to provide assistance and work to improve the quality of care in free clinics, which are increasing in number around the nation. Currently, there are more than 200 of them in 30 states.

They provide a variety of services and, as the report approved by the House points out, for those people who might not otherwise receive any health care, they are filling a real need.

The House also approved a statement on the concept of health outreach, whereby lay workers serve to bridge the cultural gap between patients, professional staff, and the community, and assist in effective delivery of health care. Among several sound reasons for using such workers, the report says, is that they free doctors and other health professionals to better utilize their time and thus extend the scope of their services. The statement recommends that the AMA, state, and local medical societies encourage the use of such personnel, and that the AMA institute educational activities for physicians and other health professionals on the use of outreach workers.

Blood Banks

The House adopted Report N of the Board, which deals with new federal regulations in regard to collection and distribution of blood. Among the recommendations to be given to a federal panel on blood banking are:

That operating standards of the American Association of Blood Banks and the American Red Cross be recognized and accepted; that physicians be represented on any national panel set up to advise on procurement or use of blood, and that programs to increase voluntary blood donation be encouraged.

Young Physicians

The Council on Long-Range Planning and Development will be expanded to include one Intern and Resident member of the AMA as a full voting Council member, the House decided. That member is to be appointed by the Speaker of the House, who subsequently announced that he intends to name Dr John Mather of the University of Maryland Hospital, outgoing chairman of the Interns and Residents business session, to the post.

Proposals to appoint an intern or resident to the Councils on Medical Education and Medical Service were deferred for further study, and the Council on Constitution and Bylaws directed to offer specific recommendations for action at the 1973 annual meeting.

For the first time in the history of the AMA, a medical student took his seat in the House of Delegates. He is George Blatti of Minneapolis, a senior medical student at the University of Minnesota medical school. In another action, the House set annual dues for student AMA members at \$15.

Elections

Three AMA members of the new Coordinating Council on Medical Education were elected by the House: Merrill O Hines of New Orleans, 1-year term; Bernard J Pisani, New York, 2-year term, and Tom E Nesbitt, Nashville, House vice speaker, 3-year term. All future elections will be for 3-year terms.

IRS Ruling

The House was informed that an Internal Revenue Service ruling — which barred physicians from withdrawing voluntary contributions to their Keogh Law plan prior to disability or age 59½ — will be revised to permit withdrawal of such contributions made to a qualified plan prior to March 6, 1972. The AMA had vigorously protested the ruling, and delegates complimented AMA staff for its "prompt and effective action."

Awards

George Hoyt Whipple MD, winner of the 1934 Nobel Prize in medicine and founder of the University of Rochester School of Medicine and Dentistry, was selected to receive the Distinguished Service Award of the AMA. Dr Whipple, now 94, received his MD degree from the Johns Hopkins University medical school in 1905. He won the Nobel Prize for his work in pernicious anemia, particularly in the use of liver in treatment.

Leslie Townes (Bob) Hope, the famed entertainer, will receive the Layman's Citation for Distinguished Service. His contribution to the Eisenhower Medical Center in Palm Springs, Calif, including its 80-acre site, totals nearly \$1.5 million. Mr Hope also has staged fund raising dinners which have brought another \$3.5 million to the center.

Both awards will be presented at the 1973 annual meeting in New York.

Respectfully submitted,

ROBERT vL CAMPBELL MD

RUSSELL S FISHER MD

CHARLES F O'DONNELL MD

WILLIAM CARL EBELING MD, Alternate

M McKENDREE BOYER MD, Alternate

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EMERGENCY MEDICAL SERVICES COMMITTEE

Mr President and Members of the House of Delegates:

Emergency medical service, one of the most important areas for system development and coordination in medicine today, has been examined and debated by this committee, and important actions have been recommended to the Council this year. In recognition of impending and significant changes in emergency medical system organization in Maryland, the Committee was raised to the status of a full committee in May 1972. Meetings are held every other month throughout the year, with excellent attendance. Actions taken or recommended include:

1) The Governor of Maryland asked for assistance in the drafting of an Executive Order to create a statewide emergency medical service network and a special institute for emergency medicine. The Committee met with his representatives several times, and recommended that the State Department of Health and Mental Hygiene division be in charge of a physician who reports directly to the Secretary, and that a different person be assigned as head of the institute. The Committee has reported to Council several times about these matters, and it is clear that much work must be done by all interested persons if cooperative regional systems of emergency medical care are to be established over the next several years.

2) In keeping with Committee philosophy which urges the active involvement of all members and all component societies, the Third Annual Seminar on Emergency Medicine was held at the Prince George's General Hospital. The papers were planned around the subject of "Pediatric Emergencies," and the attendance was excellent. Five exhibitors provided added interest and financial support. A fourth seminar is planned for 1974 in one of Maryland's other counties.

3) Spurred by an article in *Today's Health*, an AMA publication, which described Friendship Airport as one of eight major US airports without medical services, the chairman invited representatives from Friendship's management to meet with the Faculty's Subcommittee on Airport Medicine and the Baltimore City Medical Society's Committee on Disaster Medicine. They reviewed airport disaster plans and found them to require prompt updating, and that medical services, in general, were deficient. With full support of an alert airport management, the Committee recommended five consultants to assist in the development of superior medical facilities at Maryland's international airport. These physicians will provide expert advice in areas of airport medicine, international health, diseases resulting from occupational or toxic substances, general surgery, and ambulatory care.

4) Approved a nonprofit corporation developed by the Regional Planning Council to manage an emergency medical system for Baltimore and the five surrounding counties (ie, the Baltimore Standard Metropolitan Statistical Area, or SMSA), later to be linked to other regional systems through the developing State network.

5) Recommended to the Regional Medical Program, which was reviewing an application from the Regional Planning Council for the Baltimore SMSA emergency system, that any communications center should be located at a neutral location (ie, away from any hospital or medical school) which would have the greatest advantage for the purpose for which the center would be designed.

6) Carefully reviewed tentative or initial guidelines accepted by the Secretary of Health and Mental Hygiene

upon the recommendation of a non-Faculty ad hoc group, to govern conflicting jurisdictions of State Police helicopters and wheeled vehicle ambulances in the transportation of critically ill or injured persons to near or distant hospitals. The guidelines were considered inadequate and were referred again to the Secretary for revision.

7) Recommended endorsement in principle of the Alcohol Safety Action Program, an activity to study the relationship of alcohol in the body fluids of persons involved in highway accidents to the causation and severity of injury.

8) Appointed representatives to meet with the Medical Economics Committee of the Faculty to discuss the problem of third-party payment for emergency services, other than surgical, rendered in hospital emergency departments.

9) Recommended that a report of a study, which compared automobile trauma deaths in Baltimore City to those in Washington County, be prepared for submission to the *Maryland State Medical Journal*.

10) Meetings were held with emergency department physicians and other persons interested in the development of regional emergency medical systems, at the Dorchester General Hospital on the Eastern Shore and at the Washington County Hospital in Hagerstown. Much interest in the formation of compatible regional systems, that are responsive to local regional needs, was shown by the physicians in both of these areas.

Faculty members are now prominently or strategically placed on several committees that will be managing or planning emergency medical care for Maryland citizens in the coming years. These include the Faculty's own Committee, the managing group of the Baltimore nonprofit corporation, the Advisory Council to the Secretary of Health and Mental Hygiene, and the Maryland Emergency Care Advisory Council. In all of these activities, our member physicians share responsibility with several other professional groups and with concerned citizens or consumers. This Committee believes that it has a particular charge to provide a forum for the interests of Maryland's physicians, and that it will perform valuable professional functions which the others cannot accomplish.

Respectfully submitted,

JOHN B DE HOFF MD, Chairman
ROBERT T ADKINS MD
RAYMOND M ATKINS MD
WILLIAM E BEAVEN MD
JOSEPH I BERMAN MD
NIRENDRA BHADURI MD
HALUK B BONEVAL MD
LEWIS M BURDETTE MD
JAMES D CARR MD
R ADAMS COWLEY MD
RICHARD Y DALRYMPLE MD
ROBERT L DAMM MD
H VINCENT DAVIS MD
SALVATORE R DONOHUE MD
FRANK DREWS MD
PETER M FAHRNEY MD
PHILIP J FERRIS MD
MOISES FRAIMAN MD
EMMANUEL FRANCOIS MD
MARION FRIEDMAN MD
B KEN GRAY MD
MELVYN GREBERMAN MD
GEORGE H GREENSTEIN MD
ARTHUR L GUDWIN MD
J ALEX HALLER MD

GUNTHER D HIRSCH MD
 PAUL V JOLIET MD
 SIDNEY KREIDER MD
 LEO H L EY JR MD
 LAWRENCE W MALIN MD
 JAY W MCROBERT'S MD
 LESLIE R MILES MD
 PAUL G MUELLER MD
 SOO YOUNG OH MD
 EUGENE J RILEY MD
 JUANITO ROA MD
 MARTIN M ROTHSTEIN MD
 JOSEPH M SANCHEZ MD
 CHARLES J SAVARESE MD
 E RODERICK SHIPLEY MD
 GEORGE M SIMONS MD
 ROBERT F SPICER MD
 JAMES A STERLING MD
 BENJAMIN D WHITE MD
 MCRAE W WILLIAMS MD
 MR GARY GREENHUT, Advisory Member
 MR DONALD MCANENY, Advisory Member
 MR ROBERT H OSBORNE, Advisory Member
 MR PAUL MARINO, Advisory Member
 REV LESLIE E WERNER, Advisory Member

EMOTIONAL HEALTH COMMITTEE

Mr President and Members of the House of Delegates:

During the past year the Committee on Emotional Health has held eight dinner meetings with very good attendance. This type of meeting seems to be preferred by Committee members. The Committee was not divided into subcommittees this year, but various members accepted assignments to look into particular subjects. The policy of inviting residents from accredited psychiatric training institutions in Maryland to attend meetings of the Committee has been continued. The residents have been quite interested and contributed much to the discussions.

Following are matters studied by the Committee and actions taken:

- 1) Mental health in correctional institutions. Several members met with representatives of the Division of Correction of Maryland to discuss the medical services in penal institutions at a State level, and future meetings are planned. A meeting was arranged with State Senator Verda Welcome to discuss this problem. However, when the meeting was held, she was unable to attend, but her aide was present and a satisfactory discussion took place.
- 2) Drug abuse
- 3) Care of the Aged
- 4) Bertram Pepper MD, Commissioner of Mental Hygiene for Maryland, attended a meeting of the Committee and discussed the plans and activities of his Department, including differences in the problems of the counties and those of Baltimore City. He requested that the Committee give some consideration to having regional mental hospitals develop smaller units.
- 5) The Committee took action and testified on several bills introduced into the State Legislature.
- 6) Plans are being made to request a meeting, prior to the next session of the State Legislature, with legislators who will be introducing bills concerning mental health.
- 7) Requested that a member of this Committee meet with the Faculty's Legislative Committee to act as a liaison between the two committees.

Respectfully submitted,

LOUIS W TINNIN MD, Chairman
 JOSEPH R COWEN MD
 WILLIAM N FITZPATRICK MD
 LUIS FLORES MD
 GERTRUDE M GROSS MD
 ERNEST E HARMON JR MD
 STEPHEN A HIRSCH MD
 KATHERINE V KEMP MD
 EXALL L KIMBRO JR MD
 WILLIAM W MAGRUDER MD
 H THOMAS UNGER MD
 JOHN BUTCHARD MD, Advisory Member
 WILLIAM KENNER MD, Advisory Member
 STUART SILVER MD, Advisory Member

EXECUTIVE DIRECTOR

Mr President and Members of the House of Delegates:

All of the accomplishments of the Faculty are recounted in the various annual reports of the committees and officers.

In addition to the routine reports, however, I would like to express my sincere appreciation for the honor bestowed upon me at the Presidential Banquet. At that time, a most unusual gift was presented to me on behalf of the Faculty membership, a set of gold US coins. I was overwhelmed by this thoughtfulness, as was my wife who received a silver serving tray engraved appropriately to indicate her gift to the Faculty in sharing my time with her.

This year marks my 15th year of service. They have all been enjoyable. As the Faculty grows, however, it becomes more difficult than ever to know each of you as personally as I would like to. I hope you will forgive me if I can no longer recall instantaneously each member's name. Our growth has been from 2,800 to 4,500 in this period of time.

This year also marks the receipt of the initials CAE, Certified Association Executive. This is earned by a qualifying examination and by annually keeping abreast of current information in the association field by continuing educational efforts. A qualifying examination must also be taken each three years. Only 75 executives throughout the entire United States have the privilege, at this time, of using these initials following their name.

Respectfully submitted,

JOHN SARGEANT CAE, Executive Director

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FINANCE COMMITTEE

Mr President and Members of the House of Delegates:

The investment portfolio of the Faculty's special dedicated funds was reviewed with a counselor of the T Rowe Price Company by the members of the Finance Committee.

The year 1972 produced good results, although not without some disappointment. Our performance for the year was +11.3%. Over the last five years we have outperformed Dow Jones Industrial Average by 20%, and over the last ten years we outperformed Dow by two to one.

The stock market is in a negative trend and T Rowe Price predicts a poor year for 1973. Inflationary pressure is the primary concern of business and Wall St.

A summary of the portfolio at Dec 31, 1972 shows the market value of invested capital at \$1,359,618.68. The approximate income or earnings of the fund was \$28,631.88. The yield on invested capital was 3.2%.

The holdings of the Coggins Building Fund were liquidated by T Rowe Price as requested by the Faculty. The funds will be used to purchase the plot of land in Howard County.

T Rowe Price was advised that the pension reserve fund of the Faculty will be turned over to them for management in the near future. The Faculty is planning to change the pension program which will eliminate insurance in the plan and thereby remove the insurance company as the manager of the conversion fund.

Respectfully submitted,

KARL F MECH MD, Chairman

M McKENDREE BOYER MD

A C DICK MD

E W DITTO MD

THEODORE G OSIUS JR MD

HEARING AND VISION EARLY SCREENING (HAVES)

Mr President and Members of the House of Delegates:

In April 1969, the Medical and Chirurgical Faculty of the State of Maryland convened representatives of voluntary organizations and governmental agencies concerned with the early identification, through screening programs, of preschool age children who might have hearing and/or vision problems.

One of these organizations, the Maryland Society for the Prevention of Blindness, was already engaged in the vision screening of 3- to 4-year-olds through community based programs conducted by trained, supervised volunteers. No comparable screening program available to the public at large existed for detecting hearing impairment in this age child.

If such hearing screening were to be offered, a reliable screening instrument designed for use by trained volunteers would be required. The ZA III audiometer with the Verbal Auditory Screening for Children (VASC) met the latter criteria, but had not, according to our knowledge, undergone a validity study.

In 1972, a validity study was conducted by David Minear PhD, under the auspices of the Medical and Chirurgical Faculty of Maryland. This was done in conjunction with the Maryland Society for the Prevention of Blindness'

vision screening program and with the assistance of audiometric technicians.

The ZA III audiometer with the VASC was determined to be a valid screening instrument for detecting three-year-old children with educationally significant hearing problems. A combined vision and hearing screening program was established after this study, using the community-based structure already employed by the Maryland Society for the Prevention of Blindness.

United Fund approval is being sought for addition of hearing screening to the preschool vision screening program conducted by the Maryland Society for the Prevention of Blindness (a United Fund agency) in the Central Maryland area (Baltimore City, Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties). It is anticipated that little or no additional expense would be involved.

A nonprofit organization, HAVES (Hearing And Vision Early Screening) has been incorporated under the sponsorship of the Medical and Chirurgical Faculty of the State of Maryland and the Maryland Society for the Prevention of Blindness in order to seek funding for expansion of the program into counties outside the United Fund area. Private donations and funds will be solicited from professional societies, foundations, and service clubs. HAVES will reimburse the Maryland Society for the Prevention of Blindness for services performed outside of the United Fund Central Maryland area.

Contracts may be made with individual county health departments to screen children in their well-baby clinics. All children who fail either screening test will be referred to their primary source of care.

HAVES Inc, through its sponsoring organizations, is ready to plan its expansion of vision and hearing programs for three-year-olds throughout Maryland. The statewide expansion would be a gradual one so that the present high screening standards are not jeopardized and to permit follow-up of all referred children to determine the final diagnosis. Expanding the service area is planned for the fall of 1973.

Respectfully submitted,

KARL M GREEN MD, President, Board of Trustees

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JOINT PRACTICES COMMITTEE

Mr President and Members of the House of Delegates:

The Joint Practices Committee first met in May 1972 under its new name and duties to formulate regulations for use in Mobile Heart Units throughout the state. In subsequent meetings various programs designed to utilize paramedical personnel were reviewed, among them physicians' assistants, pediatric nurse practitioners, nurse-midwives, and others. Standards to govern these programs were discussed, and the Committee advised sponsoring groups as to which national organizations might be of assistance.

The Committee also considered Regulations for Delegation of Duties, which will be coordinated through the Board of Medical Examiners.

A subcommittee was appointed to discuss the role of the primary care nurse practitioner in nursing homes and educational programs. This group is reviewing programs offered in various institutions to train nurses for nursing homes, and will make appropriate recommendations.

Respectfully submitted,

ALBERT T DAWKINS MD, Chairman
MELVIN N BORDEN MD
KERMIT P BONAVIDICH MD
ELMER G LINHARDT MD
RAYMOND M YOW MD
MARIAN LANGLEY RN
WILLIAM FAIRCHILD RN
MARION I MURPHY PhD
ELEANOR REESE RN
FRANCES TOMPKIN RN
WILLIAM J KINNARD JR PhD
GEORGIA J PAYNE LPN
BEATRICE THOMAS LPN

LEGISLATIVE COMMITTEE

Mr President and Members of the House of Delegates:

This annual report to the House of Delegates can probably be summarized rather than stating what has already been provided to the total Faculty membership in the final issue of *The Assemblyman*. In that issue, our victories and defeats in the halls of Annapolis are recounted.

Health continues to be one of the prime areas of concern for legislators. Innumerable bills involving health care and the health-care system are introduced each year. Some pass. Some are amended and pass. And some fail. We believe, on the whole, that our success is equal to if not better than most organizations who have concerns over actions taken by the General Assembly.

Your Legislative Committee is composed of selected representatives, as well as a representative from each component society and from each statewide specialty group. There is sufficient interest on the part of these individuals to attend the few meetings it is found necessary for our committee to have. We would like to make more-considered decisions on legislative proposals but this year, as in the past, time is always of the essence and to call meetings of the Committee would delay testimony on bills scheduled for hearings. As a result, it is necessary to determine Faculty position on many pieces of legislation based on past experience and previous policy decisions of the House of Delegates and the Council.

It is apparent that interest in health and legislation involving the health care fields will continue to increase

during the next several years. We implore all members to make and maintain contact with their local Delegate or Senator and acquaint him with the profession's views on matters of vital concern to us all.

Respectfully submitted,

STEPHEN K PADUSSIS MD, Chairman
HUELLE E CONNOR JR MD
MARSHALL DIAMOND MD
WILLIAM J HOGAN MD
WATSON P KIME MD
B MARTIN MIDDLETON MD
J MORRIS REESE MD
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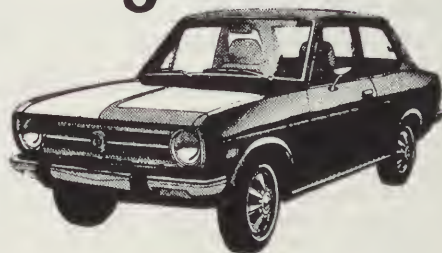
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LIBRARY AND HISTORY COMMITTEE FINNEY FUND COMMITTEE

Mr President and Members of the House of Delegates:

The library made some significant steps during this year, particularly in the field of bibliographic searching and extension of services. Plans were completed for the installation of an on-line terminal connected with the data base in the National Library of Medicine; subsequently, application was made to the Maryland Regional Medical Program for funding the purchase of an NCR-260 thermal printer to be used for this purpose. (This was later approved and the machine purchased.)

Also, Mrs Sanford attended a number of meetings at the National Library of Medicine as a member of the Regional Medical Library Task Force (the Mid-Atlantic RML, or Region IV of the Regional Medical Library Program). Many sessions have gone into planning a sound program for organizing this region under the capable direction of Mrs Erika Love. Heretofore, the National Library of Medicine has nominally been the medical library for this region because of its geographical proximity to the surrounding states and DC. Our library, because of its size and the fact that we are a net lender, meaning we lend more items than we borrow from other libraries, was designated as an Area Library by the organizational committee for Region IV. This obligates our library to assist the basic unit libraries, smaller hospital libraries with a "core library" collection of journals and books, as well as the medical and allied health communities in this area.

Throughout the year, several personnel changes occurred. The part-time position on the circulation desk was upgraded to full time and Mrs. Patricia Munoz was employed to fill this position in May. In September, Mrs Shirley Toth replaced Mrs Judith Lasson as parttime assistant in the cataloging and acquisitions department. Both Mrs Munoz and Mrs Toth had previous experience at the Enoch Pratt Free Library. These changes provided a staff of two full-time professional librarians, one professional librarian part time, one full-time assistant in charge of circulation, one full-time assistant in rare book and history of medicine mainly, one part-time assistant in cataloging and acquisitions, and two part-time student assistants.

With addition of the MEDLINE terminal and our becoming an Area Resource Library, more clerical work will be generated, probably necessitating a need for more clerical support in all departments.

Work on the revision of the rare book and history of medicine sections is nearing completion and the remainder of the shipments to Swann Galleries will be finishing in 1973. During this year, \$1667.50 was realized from sales of books sent for auction by Swann Galleries, New York City. This brings the total receipts from auction sales to \$12,442.50. Several hundred additional items will be sent for auction during 1973.

The rare book and history collection has been completely rearranged, a special catalog compiled, several standard bibliographies checked for our holdings, and this information recorded on the catalog cards.

A component society history search was initiated at the suggestion of DeWitt DeLawter MD, President of the Medical and Chirurgical Faculty, to be used as the basis for the Presidential Banquet program in 1973. It is planned that the library collect and make as complete a compilation of this information as possible so that the histories may be permanently recorded.

Another activity in the history of MED-CHI involved

researching all the available biographical sources on the life of Miss Marcia C Noyes, librarian from 1896 to 1946. Based on this reference assistance, Mrs Bernie Todd Smith, a library science student at the University of North Carolina, will present her paper entitled "Marcia Crocker Noyes, medical librarian: the shaping of a career" to the Medical Library Association in competition for the Rittenhouse Award. This award is given to a student in an approved medical library course for a manuscript applicable to medical librarianship. Up to this year the award has been \$100, but a motion was made at the MLA annual meeting to increase it to \$250. The library has a copy of this biography.

Mrs Sanford attended the Medical Library Association conference in San Diego, which included a Region IV Task Force meeting, and Mr Jensen attended the Special Libraries Association conference in Boston during May and June. Both were present at the DC, Delaware, Maryland convention and participated in the program arranged by the Baltimore Hospital Librarians Association, apparently the only group of this type in the area. Our library cooperates with this hospital-based library association and is often commended by its members for our prompt and courteous services, as also from statewide libraries.

Library Statistics—1972

Circulation	
Books	7,732
Journals	8,911
Pamphlets and VF	300
Total	16,943
Slides	36
Tapes	44
Total all items	17,023
Interlibrary loans charged out	3,505
Interlibrary loans borrowed	287
Net lender balance	3,218
Acquisitions	
Books added	558
Bound journals added	541
Total volumes	1,099
Books withdrawn	239
Bibliographies	324
Gifts	
Books	103
Journals	44
Total	147
Attendance	2,674
Telephone calls	3,953
Previous total volumes	95,857
Present total volumes (December 1972)	96,717

Respectfully submitted,

Library and History Committee

PAUL F GUERIN MD, Chairman
H BERTON MCCAULEY DDS
ROBERT GOLDSTEIN MD
GEORGE A MAXWELL MD
THOMAS C HILL MD
KATHERINE A CHAPMAN MD

Finney Fund Committee

WILLIAM H M FINNEY MD, Chairman
RICHARD W TELINDE MD
RICHARD V HAUVER MD
THOMAS G EDISON MD
D C W FINNEY MD

MARYLAND BLUE SHIELD INC BOARD OF DIRECTORS

Mr President and Members of the House of Delegates:

Again in 1972, more Maryland citizens received more health care paid for in whole or in part through the Maryland Blue Shield Plan than in any prior year.

At the end of 1972, membership in the Plan had increased by about 30,000 over that of one year earlier to a total of 1.4 million, equivalent to about 44% of the population of the area served. An estimated additional 100,000 people, another 3.3% of the area population, were being served by the Plan in its administration of Part B of Medicare and CHAMPUS.

Claims incurred in regular business during the year increased to \$43.7 million, about \$2.5 million higher than in 1971. The total of benefits paid during the year under Part B of Medicare and CHAMPUS equaled about \$18 million.

From a financial point of view, the year brought improvement over performance of the several preceding years. With administrative expense, expressed as a percentage of earned subscription income, remaining virtually unchanged from 1971, and with a small gain from underwriting amounting to about \$750,000, combined with investment income, an increase of about \$1.1 million in unallocated reserves was realized. In each of the prior three years reserves had been reduced, by an unprecedented \$2.4 million in 1971. The total of reserves at the end of 1972 was about \$3.9 million, which generally, however, would be considered only marginally satisfactory for a Plan the size of the Maryland Plan.

Another notable change that occurred in 1972 involved the rate at which subscriber utilization of covered services had been increasing. After several years during which such utilization had increased by 50% or more in some categories of services over the rate of the preceding year, the rate in 1972 showed only a very slight increase from 1971. This probably was the major contributor to the realization of a gain from underwriting and the modest addition to reserves. The effect of wage and price controls, parenthetically, was probably minor, since these restraints would have no influence over benefits paid under fee-schedule programs, and since benefits paid under usual, customary, and reasonable fee programs are based on charges from the prior year.

Thus, on the basis of membership and financial data, the year was a successful one. It is perhaps more in perspective, however, considering the basic purpose of a Blue Shield Plan, that the Maryland Plan was instrumental in the purchase of about \$44 million worth of needed health care for Maryland citizens through underwritten programs, and an additional \$18 million worth of care in its capacity as fiscal intermediary for Part B of Medicare and CHAMPUS, from nearly 5,000 physicians and a number of other health-care providers.

The year was successful also from the point of view of the Plan's continuing effort to upgrade coverage, particularly from the outdated Plan A, to better programs. The percentage of membership enrolled in Plan A was reduced to less than 5% from nearly 6% one year earlier. Enrollment in usual, customary, and reasonable fee programs was increased from 36% of membership one year earlier to 43% as of the end of 1972. The desired gravitation to better programs will be further enhanced, it is believed, by a new copayment program, introduced in 1972, under which the Plan pays

80% of usual, customary, and reasonable fees, the subscriber being responsible for the remaining 20%. During the year, plans were formulated also to develop and market in 1973 an indemnity program with a fee schedule superior to that of plan B, but without a service benefit provision, which also is expected to aid in the upgrading process.

The Maryland Plan's record of success, in 1972 as well as since its establishment, could not have been achieved without the generous support of members of the medical profession, individually and collectively. At the end of 1972 nearly 90% of the physicians in practice in the State were participating with the Plan, which fact alone is significant. It is equally significant that physicians gave generously and without compensation of their time and expertise in serving on the Plan's Board of Directors and its various committees, and that the Faculty continued to render invaluable guidance in the resolution of a variety of Plan problems. The Plan is deeply grateful for the continuing interest and support of the physicians of the State, and for the privilege of working with the outstanding individuals who provide medical care for our citizens.

Respectfully submitted,

CHARLES F O'DONNELL MD, Chairman



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Contraindications: Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

Warnings: Use during pregnancy is to be avoided.

Precautions: 1. Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of rel-

atively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**

2. **Lactic Acidosis:** This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. **Hypoglycemia:** Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American
Pharmaceutical
Association



Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical
Manufacturers
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients . . .

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25

ould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

er 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



MARYLAND FOUNDATION FOR HEALTH CARE

Mr President and Members of the House of Delegates:

At the last Annual Meeting of the House of Delegates in May 1972, the Peer Review Committee reported on steps being taken to establish a Maryland Foundation for Health Care (MFHC). As the first Chairman of the Foundation's Board of Directors, I take pleasure in reporting to you that those steps have been completed. The Maryland Foundation for Health Care was incorporated on Dec 15, 1972. Copies of the Articles of Incorporation and Bylaws of the Foundation may be acquired from the Executive Director of the Faculty. The Board of Directors of the Foundation has met five times including those times for incorporation purposes. The Executive Committee of the Board has met three times. Committees for Bylaws and Physician Relations have been formed and have met. Minutes for the various meetings indicated are available from the Executive Director of the Faculty.

The Foundation's first operational contract was signed on March 7, 1973 with the Department of Health and Mental Hygiene of the State of Maryland. That contract established the Maryland Admissions Review Program (MARF) for review and certification of Medicaid inpatient hospital admissions within the State of Maryland. Presently, the Program's Steering Committee and Program Evaluation and Criteria subcommittees are being formed. The Steering Committee, which manages the program for the Board of Directors, is made up of 16 members and is constructed as follows:

Nine physicians appointed from six established Program Regional Councils within the State

An additional physician appointed by the Foundation Board and designated as the Committee Chairman

Four nominations made by the Maryland Hospital Association

A public member appointed by the Governor of the State of Maryland

A representative appointed by the Secretary of Health from his Department

The Board of Directors, at its most recent meeting, appointed Watson P Kime MD as its representative on the Steering Committee and the Steering Committee Chairman. The Program will initiate activities in six Baltimore hospitals on June 1, 1973. Program coverage of all Medicaid admitting hospitals within the State will be completed by Oct 1, 1973. MARF Program Staff are presently being hired.

Additional information on the MARF Program and other Foundation activities was mailed to the membership of the Medical and Surgical Faculty in the Foundation's first monthly newsletter on April 6, 1973.

The Foundation has established lines of communication and working relations with the two local Maryland Foundations for Medical Care in Prince George's and Montgomery counties. Foundation staff has been directed to "assist and support local Foundations wherever feasible in their efforts towards implementation of various proposed activities." The Foundation has also been elected to membership in the American Association of Foundations for Medical Care (AAFMC).

Foundation directors and/or staff have recently attended meetings called for the purpose of discussing Professional Standards Review Organizations (PSRO) as defined in Public Law 92-603. AAFMC established a Regional Con-

ference in West Virginia to discuss PSROs, and the Conference was attended by representatives of Medical Societies and Foundations from throughout the Mid-Atlantic States. The counties of Prince George's and Montgomery sponsored a meeting in Annapolis of the component medical societies from Maryland to discuss PSROs and their relationship to activities within the State. These meetings have been very informative and have tended to clarify the organizational structure that PSROs may take as they are applied to the geographical area of the State of Maryland.

In conclusion, the Maryland Foundation for Health Care is now operational and stands ready to carry out its objectives as defined in its Bylaws and the wishes of its administrative members which are the members of this House.

Respectfully submitted:

MANNING W ALDEN MD, Chairman

KATHERINE H BORKOVICH MD

EARL C CLAY JR MD

ARTHUR E COCCO MD

W KENNETH CRUZE MD

CLIFFORD L CULP MD

JOHN R DAVIS MD

L MICHAEL GLICK MD

H HERBERT INSEL MD

PHILIP A INSLEY JR MD

LEEDS E KATZEN MD

WATSON P KIME MD

HARRY F KLINEFELTER MD

EDWARD J KOWALEWSKI MD

CHARLES H LIGON MD

CHARLES C SPENCER MD

ALAN C WOODS MD

R LANE WROTH MD

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

Mr President and Members of the House of Delegates:

More than ten years ago, Dr George G Finney Sr and the late Dr Amos R Koontz called together physicians representing all sections of the State for the purpose of forming the Maryland Medical Political Action Committee. Physicians at that time realized their future was in the hands of men other than their own ranks; and, after 30 years of activity by various other political action groups, physicians were organized also.

During this ten-year history, hundreds of hours have been devoted to the study of philosophies of the men seeking political office, especially in the US Congress. These hours have been spent in interviewing candidates seeking office such as US Congressman and US Senator. They have come willingly to be interviewed, for the name of the game is support by organizations such as MMPAC. Support means dollars with which to conduct their campaign; support means endorsement by the political action groups before which they appear; support means volunteers and the thousands of man-hours needed to staff and operate an effective campaign for their election.

In the most recent election, MMPAC activity supported candidates in six Congressional Districts, five of whom were successful in their office-seeking goal. Those we successfully supported were:

William Mills — 1st Dist
Marjorie Holt — 4th Dist
Larry Hogan — 5th Dist
Goodloe Byron — 6th Dist
Gilbert Gude — 8th Dist

In the 2nd District, the PAC aided John Bishop in his unsuccessful bid to defeat Clarence Long.

We have previously supported Paul Sarbanes in the 3rd District and he was re-elected this past year.

In addition, interviews by the Board were held with six candidates before the Primary election. Additional interviews were held by District chairmen.

During the two-year term of this report (May 1971 to 1973), a total of six meetings of the MMPAC Board were held:

May 12, 1971 (Annual Meeting)
Oct 28, 1971
March 28, 1972
May 30, 1972
Sept 26, 1972
Feb 6, 1973

Our membership this year is a record for the PAC.

While MMPAC activities may appear to be selfish in their motives, they really are not. For years, the physician's concern has been that of the patient. In his community involvement (hospital planning and patient care — fund drives for worthy community projects and institutions — time and energy devoted to religious, historical, art and musical groups — teaching services in medical institutions — supervision of new physicians in operating rooms, clinics and patient care) he has consistently placed the patient's interests ahead of his. Political action activity is just an extension of this involvement. Important as the others are, without political action, they will be "as a tinkling brass and a sounding cymbal."

As we look ahead to the next ten years, we express our appreciation to those who have led us before — George G Finney Sr MD, Howard F Kinnamon MD, William T Layman MD, Joseph H Hooper Jr MD, George G Finney Jr, MD, and DeWitt E DeLawter MD.

May we become more involved and exert an even greater influence in years to come.

Respectfully submitted,

RALMOND L MARKLEY MD, Chairman

MARYLAND STATE MEDICAL JOURNAL

Mr President and Members of the House of Delegates:

As stated in the concluding paragraph of our 1971 report, "the goals of your editors and Board are to provide an interesting, informative, helpful, well-balanced, attractively-packaged product with regularity each month and at a reasonable cost."

With a modest degree of pride, we believe those goals were attained for the 1972 year. The one word that most aptly describes 1972 is "stability."

The Editorial Board held two meetings during the year: March 6 and October 16.

Dr Flotte was reappointed to another three-year term as Editor. A long-time Board member, Dr E T Lisansky, resigned. Dr Kenneth Cruze was appointed to fill his unexpired term (through December 1973).

National advertising revenue continued about on a par with 1971. However, local advertising revenue continued to decline until the Ruehl and Company agency was replaced by the Shirley Arnowitz agency in November. A one-year contract was negotiated. A sharp increase in local advertising occurred in December and the trend is expected to continue in 1973.

The Boyertown Publishing Company continues as our printer. Printing problems were minimal during 1972. The production schedule has been tightened to get the Journal in the mail on or about the fifth calendar day but no later than the tenth of each month.

Close control was exercised over printing costs during the year. A prime example was restricting the Transactions Issue in August to material related to the Annual Meeting instead of adding it to a "normal" issue. This practice will be followed again in 1973.

There was no shortage of scientific articles in 1972. However, with exception of papers and panels from the Annual Meeting, we were able to publish most within six months of receipt.

Columns added or reinstated during 1972 included Drug Abuse, Emergency Medicine, Pathology, Maryland Medical Political Action Committee, Commission on Medical Discipline, and Peer Review.

Special issues were devoted to Drug Abuse in April and to Transactions in August; the Baltimore City Medical Society had a series of articles on HMOs in the October issue; and several papers and panels from the 1972 Annual Meeting have been published.

A different Maryland hospital was featured on the front cover each month and also "saluted" in a Journal story; this successful series continues through 1973.

In conclusion, your editors and Board pledge to continue to improve on last year's goals and accomplishments.

Respectfully submitted,

C THOMAS FLOTTE, MD, Editor

L H MILES, Managing Editor

Editorial Board:

LEON W BERUBE MD, Mechanicsville, 1974

KENNETH CRUZE MD, Silver Spring, 1973

WILBER R ELLIS JR MD, Salisbury, 1975

EDWARD S KLOHR JR MD, Baltimore, 1974

EDWARD C H SCHMIDT MD, Easton, 1973

Z B ZACHARY MD, Baltimore, 1975

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COMMISSION ON MEDICAL DISCIPLINE

Mr President and Members of the House of Delegates:

The Commission on Medical Discipline is composed of the following members whose terms expire on the dates indicated:

Manning W Alden MD	1975
Charles Bagley III MD	1974
Archie R Cohen MD	1974
Jerome J Collier MD	1974
DeWitt DeLawter MD	1973
John M Dennis MD	1975
Elmer G Lihardt MD	1973
Eli M Lippman MD	1975
Karl F Mech MD	1975

Members of the Commission consist of the following persons:

- The President of the Medical and Chirurgical Faculty
- Three members of the Board of Medical Examiners
- The Chairman of the Council of the Medical and Chirurgical Faculty
- Two practicing physicians appointed by the Secretary of Health and Mental Hygiene, from a list of nominees submitted by component societies of the Medical and Chirurgical Faculty
- Two other licensed practicing physicians in Maryland, appointed by the Secretary of Health and Mental Hygiene

The terms of Manning W Alden MD, John M Dennis MD, Eli M Lippman MD, and Karl F Mech MD expired on July 1, 1972. They were reappointed to serve on the Commission through July 1, 1975.

Cases Referred to the Commission on Medical Discipline of Maryland Jan 1, 1972—Dec 31, 1972

Summary

13 cases considered by the Commission:

- 3 professional incompetence
- 3 violation of narcotic laws
- 3 unprofessional conduct
- 2 advertising
- 1 illegal abortion
- 1 license suspended in another state

9 Cases pending:

- 4 unprofessional conduct
- 3 violation of narcotic laws
- 1 professional incompetence
- 1 license suspended in another state

Action Taken

- 1 license to practice Medicine and Surgery in Maryland revoked for professional incompetence
- 1 reprimand for being guilty of immoral conduct as a physician
- 1 probation for having previously violated narcotic laws, but being found by the Commission to be capable of practicing
- 2 cases closed by death of defendants, both having been charged with professional incompetence after having been addicted to narcotics, one before completion of his hearing before the Commission, and the other physician after having his license revoked and while awaiting the Court to hear his appeal
- 4 cases closed by the Commission with no action taken:
 - 1 professional incompetence — lack of evidence

- 1 solicitation — reprimand by the Commission overturned by the Court
- 1 illegal abortion — law ruled unconstitutional in Federal Court
- 1 unprofessional conduct — lack of evidence

Revocation

One physician's license to practice medicine and surgery in Maryland was revoked.

Carrie I Hearn MD

A formal hearing was conducted in the case of Dr Hearn, who was charged with professional or mental incompetence on the basis of having written prescriptions for persons not under her care. Mental and physical examination and her appearance before the Commission substantiated the charges. After having been given the chance to voluntarily surrender her license to practice, and failing to do so, the Commission revoked her license to practice medicine. The revocation has been appealed to the Court, but the appeal has not been heard at this time.

Reprimand

One case was closed by the Commission following a reprimand after the physician was found guilty of immoral conduct in his practice as a physician.

Jose A Pagan-Lugo MD

Dr Pagan-Lugo was accused by a patient of having performed unprofessional acts upon her breast during a physical examination, and of requesting her to have an illicit sex act with him. After hearing all testimony, the Commission concluded that he was guilty of immoral conduct in his practice as a physician, and ordered that he be reprimanded.

Probation

One physician was placed on probation for having previously violated the narcotic laws, though he was allowed to continue practice subject to certain conditions.

S Ralph Andrews MD

Dr Andrews admitted to the Commission to having been an addict. However, he had been under competent medical treatment and was no longer addicted. Since he was no longer addicted and since he was needed in his local community, Dr Andrews was allowed to continue the practice of medicine on the following conditions:

- 1) That he submit to the Commission monthly a list of all narcotic prescriptions for audit purposes
- 2) That he report twice weekly to the Health Department for urine examination for narcotics
- 3) That he discontinue dispensing drugs on the restricted list

That he return quarterly for follow-up by the Commission

Closed by Death

Two cases were closed by death of the defendants. Both had been charged with professional incompetence, having been addicted to narcotics. One deceased before completion of his hearing before the Commission, and the other after having had his license to practice medicine revoked and while waiting for the Court to hear his appeal.

Richard Edenbaum MD

Dr Edenbaum was charged with professional or mental incompetence as a result of having been addicted to narcotics. He admitted to having been an addict for several years up until two years previously. Testimony at the Commission hearing and clinical psychological testing in-

licated severe brain damage. While awaiting further psychiatric and psychological testing, Dr Edenbaum was found dead.

Patrick F Dougherty Jr MD

The case of Dr Dougherty had been heard by the Commission the previous year and his license to practice medicine in Maryland revoked when he was found to be professionally incompetent after having been a known and admitted drug addict. Dr Dougherty had appealed the revocation of his license to the Court, and just prior to the hearing of the appeal in the Baltimore County Court, he was found dead.

Also Closed

Four other cases were considered closed: two for lack of evidence, one reprimand was overturned by a Court, and one because the law under which the physician was convicted was ruled unconstitutional by the Federal Court.

Respectfully submitted,

JOHN M DENNIS MD, Chairman
MANNING W ALDEN MD
CHARLES BAGLEY III MD
ARCHIE R COHEN MD
JEROME J COLLIER MD
DeWITT DeLAFTER MD
ELMER G LINHARDT MD
ELI M LIPPMAN MD
KARL F MECH MD

MEDICAL ECONOMICS COMMITTEE

Mr President and Members of the House of Delegates:

During the past year, the Committee was asked to present a program at the Semiannual Session dealing with Medical Malpractice. Arrangements were completed during the first part of the year, and the program presented turned out to be outstanding. The number of persons in attendance was gratifying to the sponsors of the program and the proceedings received considerable press coverage.

The first of the reports required by House Bill 494, legislation that requires all insurance carriers to report to the Commission on Medical Discipline all cases closed out, together with settlements made, judgments awarded and other costs, was made available late in 1972. It is too early to indicate any trend from these reports.

The question of forming our own insurance company to provide malpractice insurance is still under discussion within the Committee. It is hoped this issue can be resolved during the next year.

The Committee continues to review questionable fees referred to it by either the insurance carrier or by the physician whose fee is being questioned or denied by the carrier. Most of these are resolved to mutual satisfaction, in consultation with the specialty groups. Perhaps one of the most important functions of the Committee is acting as an arbiter between the St Paul Companies and the individual physician when the company is questioning continuation of his professional liability insurance. Several cases of this category were heard during the past year, although some physicians decline to present their viewpoints on the matter to the Committee.

Much attention has been given to an alternate plan to the present system of court suit in actions against physicians. Consultation has been held with hospital administration, medical staff representatives, legal counsel, and

Faculty staff to ascertain if the arbitration approach can be implemented in Maryland on a voluntary basis. Present legislation on Maryland's statute books permits this. To date, not much progress has been made in offering this alternative.

We are still continuing to struggle with some type of educational program to our physicians in the area of professional liability. This is difficult to implement and more difficult to ascertain how it should be done. Our attention will continue to be directed toward accomplishing this objective.

Your Committee has also suggested to both medical schools that some type of program involving legal medicine be included in the curriculum. Again, little progress has been made in this area.

The Committee introduced Resolution 5A/73 to the House of Delegates. After the Reference Committee hearing determined a negative recommendation on its adoption, a substitute resolution was adopted by the Committee to be offered at the time of the Reference Committee report.

Respectfully submitted,

W KENNETH MANSFIELD MD, Chairman
ARTHUR BAITCH, MD
MARTIN BERGER MD
GAYLORD L CLARK JR MD
FRED COLE JR MD
DONALD H HOBBS DDS
BERNARD S KARPERS MD
SAMUEL M M LUMPKIN MD
ALFRED S NORTON MD
HAROLD R TRITCH JR MD
G J SCHIPPER MD
HANS WILHELMSSEN MD
JAMES G ZIMMERLY MD

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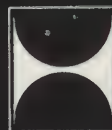
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MEDICINE AND RELIGION COMMITTEE

Mr President and Members of the House of Delegates:

Although no formal meetings of the Committee were held during the year, the chairman was active in various ways, attending state and regional meetings. A seminar was in the planning stage, but not fully developed during the year. The Committee hopes to become more active in the future.

Respectfully submitted,

ARCHIE R COHEN MD, Chairman*
ROBERT W FARR MD
CLAUDE D HILL MD
DONALD W MINTZER MD
REV WALTER T GOUGH
REV CARROLL R GUNKEL

*deceased March 7, 1973

MED-CHI INSURANCE TRUST

Mr President and Members of the House of Delegates:

The Med-Chi Insurance Trustees are happy to report another very successful year of operation. Enrollment increased in all programs and subscription income was substantially greater. A short progress report on each program follows:

The *Accident and Sickness and Major Medical programs* underwritten by the Hartford Accident & Indemnity Company enjoyed favorable experience. During 1972, 181 new policies were issued and 67 participants increased their coverage under the plan. Also 70 new policies were issued to medical assistants employed by Faculty members. Because of the high participation and favorable claims experience, the Trustees approved additional benefit liberalizations to be effective March 1, 1973: 1) increase Major Medical maximum payment from \$37,500 to \$75,000 for most illnesses; 2) increase private room and board from maximum of \$80 to \$100; 3) change in coinsurance percentage whereby after a 90% reimbursement of the first \$5,555 of covered expenses has been made, the Company then pays 100% of additional covered expenses on that claim; 4) increase in the maximum payment period for Sickness Total Disability from seven years to ten years for doctors under age 58. Other possibilities of improving the plans are being studied. Additional changes may be effected later in 1973.

The *Blue Cross and Blue Shield group* is a 70-day plan with Diagnostic III coverage. Medical assistants employed by Faculty members are also eligible for participation. Enrollment in the plan reached a new high in 1973. The Trust has been informed that the premium will be reduced substantially in 1973.

The *Business Expense Disability Program* underwritten by the St Paul Company has increased its number of subscribers. There were 126 new applicants in 1972.

The *Life Insurance program* underwritten by the Minnesota Mutual Life Insurance Company offers up to \$50,000 of coverage. A dividend of 12% was declared by the company. Each participant had the option of receiving a check or reducing his next premium payment.

The *Decreasing Term Life Insurance program* underwritten by the Occidental Life Insurance Company is available to members who wish to supplement their other life insurance coverages. Many benefits in this plan are not available elsewhere, including a conversion privilege. During the year there were 35 new applicants.

The *Med-Chi Members Retirement Plan* continued

to grow in 1972. As of the end of the year, there were 415 plans with 704 participants. The Net Asset Value of the Equity Fund at year-end totaled \$5,091,403. The unit value was \$1.85. This represents a 17.7% increase in growth for the year 1972 and an 85% increase since the plan's inception five years ago.

The Financial Statement of the Med-Chi Insurance Trust for the year ended Dec 31, 1972 can be found in the Treasurer's audited reports located elsewhere in this publication.

The Med-Chi Insurance Trustees wish to express their gratitude for the cooperation and support of the Faculty members. Continued enthusiastic support will ensure the future success of our programs.

Respectfully submitted,

PAUL F GUERIN MD, Chairman
ADRIAN M COHEN MD
WILLIAM J McCLAFFERTY MD
RICHARD F MOSCHELL MD
ALFRED S NORTON MD
RICHARD A YOUNG MD

MEDCOLEGAL COMMITTEE

Mr President and Members of the House of Delegates:

The full Medicolegal Committee met once during the year, with the subcommittees meeting more frequently.

The Subcommittee on Interprofessional Relations considered several disputes between physicians and attorneys concerning unpaid fees for preparation of reports, and several complaints regarding the amount of the fee. Most of these disputes were solved within the subcommittee's framework.

The Symposium Subcommittee sponsored "The Right To Die," presented in January 1973 at the Lord Baltimore Hotel in conjunction with the Bar Association's Mid-Winter Meeting. Physicians representing various specialties participated in this program, along with a judge, who served as moderator. The symposium stressed philosophical viewpoints rather than personal opinions. The Committee plans to continue its symposium program in the coming year.

Respectfully submitted,

HOWARD F KINNAMON MD, Chairman
VERNON R CROFT MD
W BOWDOIN DAVIS MD
JAMES DRINKARD MD
H LOGAN HOLTGREWE MD
ROY V LAND JR MD
RICHARD J OTENASEK JR MD
LAWRENCE L PACKER MD
EDWIN F RUZICKA MD
JAMES G ZIMMERLY MD
WAYNE C SPIGGLE MD
CRAWFORD BROWN MD
DAVID L BOWERS Esq
CHARLES E BROOKS Esq
BARBARA PRICE DAY Atty at Law
CHRISTOPHER A HANSEN Esq
M KING HILL Esq
ELSA R KAUFMAN Atty at Law
DAVID KAYSON Esq
JOHN F MUDD Esq
JOHN J O'CONNER JR Esq
JEROME J SEIDENMAN Esq
WALTER R TABLER Esq
ERNEST THOMPSON Esq

NOMINATING COMMITTEE

Mr President and Members of the House of Delegates:

The following names are being presented for your consideration for election to office. Those elected will assume office at the conclusion of the 1974 Annual Meeting unless otherwise indicated.

President-elect

Manning W Alden MD, Annapolis
(President-elect 1973-74)
(President 1974-75)

First Vice President

J Parran Jarboe MD, La Plata (1975)

Second Vice President

William G Speed III MD, Baltimore (1975)

Third Vice President

Robert C Angle MD, Bethesda (1975)

Secretary

William A Pillsbury MD, Timonium (1975)

Treasurer

Robert B Goldstein MD, Baltimore (1975)

Councilors

Central District

Albert M Antlitz MD, Baltimore (1977)
Joseph I Berman MD, Baltimore (1977)
Katherine H Borkovich MD, Baltimore (1977)
James B Brooks MD, Baltimore (1977)
John R Davis Jr MD, Baltimore (1973-76)
Roland T Smoot MD, Baltimore (1977)

Eastern District

E Kent Carney MD, Salisbury (1977)

South Central District

Francis C Mayle Jr MD, Bethesda (1977)
Barry Rosenberg MD, Hyattsville (1977)
Merton L White MD, Silver Spring (1977)

Southern District

Henry L Burke III MD, La Plata (1977)

Western District

Herbert H Leighton MD, Oakland (1973-76)

Delegate to the American Medical Association

Charles F O'Donnell MD, Towson
(Jan 1, 1974 — Dec 31, 1976)

Alternate Delegate to the American Medical Association

John M Dennis MD, Baltimore
(Jan 1, 1974 — Dec 31, 1976)

Committee on Program and Arrangements

Sheldon C Kravitz MD, Baltimore (1974-78)

Library and History Committee

Margaret L Sherrard MD, Baltimore (1974-79)

Finney Fund Committee

Richard V Hauver MD, Hagerstown (1974-79)

Board of Medical Examiners

John E Adams MD, Towson (June 1973-June 1977)
DeWitt E DeLawter MD, Bethesda
(June 1973-June 1977)

Respectfully submitted,

JOHN F SCHAEFER MD, Chairman, Baltimore
HENRY L BURKE III MD, Southern Dist, La Plata
MELVIN B DAVIS MD, Central Dist, Dundalk
WILLIAM R GRECO MD, South Central Dist, Riverdale
MARGARET L SHERRARD MD, Member-at-Large,
Baltimore
JOHN R SMITH MD, Eastern Dist, Centreville
ROBERT J THOMAS MD, Western Dist, Frederick

OCCUPATIONAL AND ENVIRONMENTAL HEALTH COMMITTEE

Mr President and Members of the House of Delegates:

Three meetings of this committee were held during the year, and many projects were discussed and acted upon. A policy statement on employment of addicts in industry was drafted and approved by the Committee.

A survey was made by the Committee of material in the Faculty library concerning occupational health. It was found that the quality of the literature is excellent, and that it covers a wide range, including books on industrial toxicology, occupational diseases, occupational therapy, and ecology. Many journals are in the library which can provide additional information. The Committee is grateful to the library staff for their cooperation in this project.

The Committee invited a guest speaker from the State Department of Health and Mental Hygiene to discuss the implementation of the Maryland Occupational and Safety Health Act. Several recommendations were made to improve coordination between the Departments of Health and Labor.

Respectfully submitted,

CARLOS VILLAFANA MD, Chairman
ROBERT BRANDT MD
WALTER E FLEISCHER MD
JAMES FRENKIL MD
HERMAN J HALPERIN MD
WILLIAM J McCLAFFERTY MD
DONALD J ROOP MD
PERRY STEARNS MD

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PEER REVIEW COMMITTEE

Mr President and Members of the House of Delegates:

Your Peer Review Committee has met almost monthly during the past year, with meetings lasting for a minimum of three hours or more. Much has been accomplished, not only in working with local peer review committees, but in determining and outlining our goals and objectives.

Much has been said in criticism of peer review activities. However, nothing is heard about the cases where it is found the physician appropriately hospitalized or cared for a patient. Much is said about those cases where physician judgment is in question.

Despite the many criticisms leveled at our group, it is felt that activity in this area must continue. Failure to act responsibly will result in others assuming this activity thus further encroaching on the prerogatives of medicine.

Cases have been received from commercial insurance carriers, the Blues, and individual physicians, as well as other sources. Each has been carefully investigated either on a local level or, where necessary, by the State peer review group. Several appeals have been heard from decisions at the local level. Under Faculty Bylaws the State review group can act as an appeal mechanism if either the physician or the carrier is not satisfied with the local-level decision. It is truly felt that the peer review activity is becoming more educational and less punitive.

However, when individuals practicing medicine are found to be woefully deficient in their knowledge, either because of age, senility, or poor training, the Committee frequently has no choice but to suggest that the physician retire from active practice. This occurred in two cases this past year; and primarily involved physicians who were prescribing controlled dangerous substances in an indiscriminate manner. Other committees of the Faculty are also referring cases to us. The Physician/Patient Relations Committee and the Subcommittee on Medical Treatment and Drug Programs, where cases are brought to their attention that question the quality of medicine being delivered by the physician, refer them to peer review for consideration.

The Committee is now turning its attention to those cases it considered some time ago. A reevaluation will take place on the basis of present information to ascertain if physicians who appeared before it some time ago have improved their practices. This is an important evaluation, to see if the educational aspect of peer review is bearing fruit. The first of these cases is now under consideration.

The Maryland Foundation for Health Care, authorized by the House of Delegates in September 1971 on the recommendation of our Committee, is now active and conducting preadmission review of all Medicaid hospitalization cases. It is anticipated that further activity by the Foundation will include other types of review such as drug-prescribing practices of physicians and office-utilization practices, as well as many others. It is also anticipated that similar preadmission hospital review will gradually be extended to all patients, regardless of the form of payment. Several cases have been considered on referral from the St Paul Companies in connection with physicians who have had suits instituted against them, the circumstances of which question the physician's capabilities. Initial results of investigations in this area find that many times these physicians are not aware that the quality of medicine being delivered has deteriorated.

The Committee is working closely with statewide specialty groups as well as local peer review committees. Cases are referred to such groups for peer review, particularly when norms are to be established or considered. These groups have been extremely helpful in handling such matters. While all have indicated their cooperation is available, we would like to single out the Maryland Society of Internal Medicine as having done a stellar job in this area.

A summary of activity by the Committee is as follows:

- 52 Cases received for review
 - 19 cases referred to components
 - 5 cases heard on appeal
 - 2 cases heard de novo
 - 17 cases pending at end of term
 - 8 cases found for physician
 - 12 cases found for complainant

Respectfully submitted,

ARTHUR E COCCO MD, Chairman
KATHERINE H BORKOVICH MD
EARL C CLAY JR MD
CLIFFORD L CULP MD
JOHN R DAVIS MD
J ROY GUYTHER MD
LEEDS E KATZEN MD
WATSON P KIME MD
HARRY F KLINEFELTER MD
EDWARD J KOWALEWSKI MD
CHARLES H LIGON MD
ALAN C WOODS MD

PHYSICIAN/PATIENT RELATIONS COMMITTEE

Mr President and Members of the House of Delegates:

Your Committee met almost monthly during the past year reviewing cases referred to it for consideration, as well as making policy decisions in connection with ethical governance of the profession.

In accordance with the decision of the Council, the Committee has approved appropriate professional corporation names where more than five physicians are involved in such corporations. It has also continued to approve Yellow Page telephone directory listings that fall outside of guidelines adopted by the Council.

Major decisions of the Committee have been reported in the *Maryland State Medical Journal* so that individual members are aware of the changing mores of the profession. Some of these reported include:

- 1) Permitting listing of physicians' names in a directory published in Columbia Md. This permission was granted provided that all physicians in the community were contacted prior to publication of such directory; provided there was no charge for this service; and provided the physician had a choice as to whether he should or should not have his name in the directory.
- 2) It was deemed ethical for a physician to make a charge for completion of insurance claim forms, where the time and effort involved warranted such a charge.
- 3) The use of bank cards to charge professional services was also approved provided certain standards were met. These are outlined in the committee minutes and have already been published in the *Journal*.

4) Approved the charging of interest on past-due accounts that involve litigation on the part of the patient. In all cases, the patient should have the option of making immediate payment without interest; the fee charged should be paid regardless of the outcome of the legal side of the case.

5) Determined that release of medical data to credit-reporting agencies was unethical unless certain safeguards were followed.

6) Adopted a policy statement on the employment of addicts in business and industry.

7) Condemned actions on the part of some physicians who refuse to accept or see certain classes of patients, such as Medicaid recipients; and developed an addition to the previous statement regarding nondiscrimination by physicians.

Advertising and solicitation, directly or indirectly, continues to be a problem to the Committee. Hardly a meeting goes by without a question in this area being discussed or brought to the attention of the Committee. While much of this activity occurs because of ignorance, it nonetheless must be stopped promptly or the entire ethical structure of the profession will deteriorate.

The Committee is currently struggling with the problem of nonprofit groups becoming known to the public. A special subcommittee has been named to pursue this problem and make recommendations thereto.

Another continuing problem involves so-called "multiphasic screening" units. Unfortunately, the services of these units are frequently sold to unsuspecting members of industry or the public as a substitute for an annual physical examination by a physician. Reports of the results of such tests are frequently relayed to the family physician who has not requested them and who is not aware that his patient has received this service. The reliability of such tests and their applicability to the patient's health is questionable.

As has been the custom for several years, the two publications of the Faculty, *Laws, Rules, and Regulations with Which Physicians Must Comply* and *Compendium of Ethical Decisions*, will be updated and published again in the summer of 1973.

In September 1972 the name of our Committee was changed from Mediation Committee to Physician/Patient Relations Committee.

Your Committee would be remiss if it did not express its appreciation to the staff of the Faculty who prepare agendas, send out meeting notices, capture the sense of our deliberations, and do much to make the wheels turn smoothly.

Respectfully submitted,

LOUIS J KOLODNER MD, Chairman
ROBERT G ANGLE MD
RICHARD D BAUER MD
KATHERINE H BORKOVICH MD
HENRY A BRIELE MD
VERNON R CROFT MD
RUSSELL S FISHER MD
ROBERT B GOLDSTEIN MD
WILLIAM R GRECO MD
HILARY T O'HERLIHY MD
KENT E ROBINSON MD
JOHN F SCHAEFER MD
ARTHUR G SIWINSKI MD
ROLAND T SMOOT MD
HENRY G WELCOME MD
C VERNON WILLIAMSON MD

Should children be deprived of milk because of "lactose intolerance?"

No, according to the Protein Advisory Group of the United Nations.

In a special report, the PAG stated "It would be highly inappropriate, on the basis of present evidence, to discourage programs to improve milk supplies and increase milk consumption among children because of fear of milk intolerance." The statement emphasizes that low lactase activity and results obtained in tests with high lactose loads are not adequate indications of milk intolerance.

The statement also affirms the advisability of using milk as an excellent source of protein in child feeding programs.

Dairy Council is sponsoring further research on lactose intolerance. This is just another of the many areas of interest of Dairy Council, in the pursuit of better health for everyone through sound nutrition practices.

**DAIRY COUNCIL
UPPER
CHESAPEAKE BAY**

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Balto., Md. 21212

**DAIRY COUNCIL
GREATER
METROPOLITAN WASH.**

1511 K St. N.W.
Wash., D. C. 20005

PREVENTIVE MEDICINE AND PUBLIC HEALTH COMMITTEE

Mr President and Members of the House of Delegates:

This Committee is composed of the Chairmen of ten subcommittees plus several members who are not chairmen of subcommittees and a representative from the Committee on Emotional Health. The ten subcommittees are: Adult Health, Airport Medicine, Alcoholism, Child Welfare, Human Ecology, Infectious Diseases, Immunization Practices, Maternal Welfare, Medical Aspects of Sports and Traffic Safety.

Subjects considered and actions taken during the year included:

1) Established a joint Committee with the Dept of Transportation in implementing Senate Joint Resolution 16 which requests the establishment of health facilities at Friendship Airport.

2) Published in *The Assemblyman* of the Faculty a notice of the availability of assistance from members of the Subcommittee on Alcoholism for any physician with the disease of alcoholism.

3) Recommended that all physicians alert patients to whom they are prescribing tranquilizers of the danger of consuming alcohol.

4) Passed a resolution opposing the discontinuation of admission of acute alcoholics to State Mental Hospitals, which was approved by the Executive Committee and forwarded to the Secretary of Health and Mental Hygiene.

5) Recommended that the Division of Alcoholism Control of the State Department of Health and Mental Hygiene receive more funds and prominence.

6) Developed liaison between the Subcommittee on Alcoholism and the Maryland Comprehensive Health Planning Agency.

7) Studied the problem of discrimination of Union Insurance Plans against alcoholism.

8) Actively interested in and concerned with planning for centralized or regionalized perinatal intensive care units in Maryland.

9) Endorsed the screening for various metabolic diseases which are treatable in the newborn by using the same blood sample as for PKU testing.

10) Endorsed legislation to lower the blood alcohol level from 0.15% to 0.10%.

11) Studied the problems of rabies immunization for dogs.

12) Looked into the problem of cybernetics in Child Welfare.

13) Upon referral from the Council of the Faculty have been reviewing and making recommendations regarding the Crippled Children's Program in Maryland being extended to include more services in outlying inpatient facilities.

14) Studied the matter of insurance coverage for the newborn.

15) Discussed matters such as legislation dealing with child welfare, guidelines for local school health councils, and guidelines for screening children (6-12 yrs) eligible for Title XIX.

16) Requested and obtained approval from the Secretary of Health and Mental Hygiene for a Med-Chi representative to serve on the Air Quality Advisory Council. This was a "non-voting" appointment the reason for which was that on said Council there is to be only one physician and one, appointed by the Department of Health and Mental Hygiene, is already serving.

17) The Chairman of the Subcommittee on Human Ecology attended the AMA Air Pollution Medical Research Conference.

18) A meeting was held with Secretary of State Planning where "The Role of Planning in the Functions of the Maryland Council on the Environment" was discussed.

19) Because of the publicity regarding deaths from liver disease of persons receiving isoniazid, the standard anti-tuberculosis drug, the first meeting of the Subcommittee on Infectious Diseases was devoted entirely to this matter. A letter was sent to all physicians in Maryland in hopes of clarifying the situation.

20) Established a committee of six physicians to work with the State Health Department to clarify the suspected cases of INH Hepatitis which may have occurred at their institutions within the last several months.

21) The Chairman of the Subcommittee on Infectious Diseases attended a TB Conference and action was taken by the Subcommittee on recommendations made at that time.

22) Supported female culture screening program for gonorrhea.

23) Opposed premarital blood testing for syphilis.

24) Ad hoc committee reviewed 13 charts of cases found to have had INH hepatitis.

25) Reviewed with the Department of Health and Mental Hygiene recommendations for smallpox immunization of persons at high risk. This was done following passage of a bill in the State Legislature which repealed the requirement for said immunization of school children and which specified that regulations be established for individuals in certain categories of employment.

26) Established, in conjunction with Department of Health and Mental Hygiene, revised immunizations required for school children.

27) Discussed per diem insurance coverage up to ten days hospitalization for normal pregnancy and therapeutic abortions for wed and unwed patients by Blue Cross and Blue Shield.

28) Activity of the Subcommittee on Maternal Welfare has been concerned with abortion legislation. As the abortion bill was not passed in the last session of the State Legislature, the Subcommittee has devoted its efforts in developing Guidelines for Physician Performance of an Induced Abortion and Standards for Outpatient Facilities for Abortion Services.

29) Pursuing the matter of perinatal mortality.

30) A sixth Annual Seminar on Medical Aspects of Sports was held in December and plans for the Seventh Annual Seminar are being conducted.

31) Conducted a review of new guidelines for sports injuries.

32) Chairman of the Subcommittee on Medical Aspects of Sports attended the Nineteenth Annual Meeting of the American College of Sports Medicine.

33) Endorsed the use of mouthguards by all lacrosse players.

34) Endorsed the Baltimore Alcohol Safety Action Project (ASAP) with a representative attending several of its meetings.

35) Approved publishing in the local newspapers a box score with the names of individuals convicted for drunken driving. This is now being done.

A Subcommittee on Adult Health has recently been appointed and it is hoped many important issues can be discussed and necessary action taken by this Subcommittee

during the coming year.

Respectfully submitted,
HOWARD J GARBER MD, Chairman
RUDIGER BREITENECKER MD
ROBERT L CAVENAUGH MD
EDWARD DAVENS MD
JOHN P FAIRCHILD MD
KARL M GREEN MD
CLAUDE D HILL MD
JOHN H HIRSCHFELD MD
D FRANK KALTREIDER MD
MICHAEL L LEVIN MD
JULIUS LOEBL MD
DAVID M PAIGE MD
GEORGE M RAMAPURAM MD
ELIJAH SAUNDERS MD
GEORGE SHARPE, MD
RAYMOND P SRSIC MD
PERRY STEARNS MD
JEAN R STIFLER MD
RAMSAY B THOMAS MD
BENJAMIN D WHITE MD
J KING B E SEEGAR MD

Subcommittee on Alcoholism:

JOHN H HIRSCHFELD MD, Chairman
CONRAD B ACTON MD
ARISTIDES C ALEVIZATOS MD
EDMUND G BEACHAM MD
STANLEY J BOCIEK MD
JOHN R DAVIS MD
SEANA HIRSCHFELD MD
ISADORE KAPLAN MD
HARRY F KLINEFELTER MD
LEONARD M LISTER MD
ABRAHAM M SCHNEIDMUHL MD
ROLAND T SMOOT MD
IRVING J TAYOR MD
MAXWELL N WEISMAN MD
EDGAR J WEISS MD
REV HARRY E SHELLEY Advisory Member
MR LUDWIG L LANKFORD, Advisory Member

Subcommittee on Airport Medicine:

JULIUS LOEBL MD, Chairman
DONALD BARRICK MD
JOHN B DE HOFF MD
ARIS T ALLEN MD
JAMES E TOHER MD

Subcommittee on Child Welfare:

RAYMOND P SRSIC MD, Chairman
R M N CROSBY MD
JOHN A GRANT MD
WILSON L GRUBB MD
MURRAY M KAPPELMAN MD
EDWARD J KOENIGSBERG MD
JOSEPH J McDONALD MD
LAWRENCE C PAKULA MD
JOHN L PITTS MD
MARGARET L SHERRARD MD

Subcommittee on Human Ecology:

ROBERT L CAVENAUGH MD, Chairman
GEORGE A BEDON MD
HARRY L BERMAN MD
NICHOLAS GIARRITTA MD
IRVIN HYATT MD
MILTON B KRESS MD
J BRETT LAZAR MD
JOHN E MILLER MD
CHARLES B PAYNE MD

RICHARD L RILEY MD
ROGER THEODORE MD
WILLA TOMMANEY MD

Subcommittee on Immunization Practices:

KARL M GREEN MD, Chairman
CHESTER C COLLINS MD
ROBERT J DAWSON MD
ROBERT E FARBER MD
HOWARD J GARBER MD
EDWARD J KOENIGSBERG MD
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J BRETT LAZAR MD
GEORGE H MITCHELL MD
LAWRENCE C PAKULA MD
JOHN L PITTS MD
MARGARET L SHERRARD MD
JOHN D STAFFORD MD
ROBERT E YIM MD
MR WAYNE BOBBITT, Advisory Member

Subcommittee on Infectious Diseases:

MICHAEL L LEVIN MD, Chairman
FRANK CALIA MD
HERBERT L DUPONT MD
ANDREW SCHWARTZ MD
E WALTER SHERVINGTON MD
JOHN D STAFFORD MD
WILLIAM H WOOD MD

Subcommittee on Maternal Welfare:

D FRANK KALTREIDER MD, Chairman
GEORGE H DAVIS MD
RAFAEL GARCIA-BUNUEL MD
JOHN S HAUGHT MD
JOHN A HAWKINSON MD
MERVYN L CAREY MD
HUGH B MCNALLY MD
HAROLD ROSEN MD
EDWIN R RUZICKA MD
JOHN E SAVAGE MD
J KING B E SEEGAR MD
JOHN WHITRIDGE JR MD
HERBERT L YOUSEM MD

Subcommittee on Medical Aspects of Sports:

RAMSAY B THOMAS MD, Chairman
JOSEPH ALVAREZ MD
CHARLES M HENDERSON MD
G OVERTON HIMMELWRIGHT MD
HERBERT W LAPP MD
CLARENCE MCWILLIAMS MD
SHERMAN S ROBINSON MD
EDGAR P WILLIAMSON MD
JOHN H KAHNERT PhD, Advisory Member
MR AL MALONE, Advisory Member
MR JOHN MANLEY, Advisory Member
MR JOHN E MOLESWORTH, Advisory Member
MR WILLIAM NEIL L III, Advisory Member
PHILIP H PUSHKIN DDS, Advisory Member

Subcommittee on Traffic Safety:

RUDIGER BREITENECKER MD, Chairman
TIMOTHY D BAKER MD
RUTH W BALDWIN MD
JOHN B DE HOFF MD
IRENE L HITCHMAN MD
PAUL V JOLIET MD
HOWARD F KINNAMON MD
ABRAHAM J MIRKIN MD
PERRY STEARNS MD
ROBERT J WILDER MD

PROGRAM AND ARRANGEMENTS COMMITTEE

Mr President and Members of the House of Delegates:

Both the 1972 Semiannual and 1973 Annual Meetings, under this Committee and its subcommittees, recorded the highest attendance ever at a scientific session. This bespeaks its success.

The Semiannual Meeting was held in Ocean City Md by popular demand. All sessions were held at the Convention Hall; the facilities were adequate and the cooperation of its personnel was excellent. The total registration was approximately 500, with about 150 persons attending each scientific session. As in previous years, a meeting of the Woman's Auxiliary, a banquet, and the ever-popular crab feast were held.

The format of the 1972 Annual Meeting was followed for the Annual Meeting in April 1973 with specialty societies cosponsoring the scientific program, and having three concurrent sessions daily. In addition, there was considerable input into the planning by the assistant deans and the various departments at both the University of Maryland and the Johns Hopkins medical schools.

The attendance at all of the scientific sessions was excellent, particularly in view of the fact there were concurrent sessions. Many of the individual sessions attracted between 100 and 175 physicians. This large attendance at the scientific sessions is encouraging to the Committee as the primary purpose of the meetings is continuing medical education.

The annual luncheon this year was listed as a "Lunch and Learn Session," with more tables and moderators than in the past several years. It was completely sold out with several tables enlarged to accommodate more than the usual ten persons. Approximately 300 persons attended the annual Presidential Reception and Banquet, with all comments about the function being complimentary. Another feature of the Annual Meeting this year was a Past-Presidents' Dinner. It was well attended and received by many of the former presidents and their wives. The Hospitality Night for the members of the Faculty and the exhibitors, as always, was most popular.

The Health Evaluation Tests were performed efficiently, for the tenth consecutive year, by a hard-working Subcommittee, who spent many long hours planning and carrying out these tests. Through the efforts of the members of the Subcommittee and the cooperation of the Maryland Blue Cross in the use of its computer, the results have been mailed to the examinees more promptly than ever. As a result of a poll taken in 1972, a nominal donation was requested this year. The response was good and these tests, with the services of the many volunteers, are now self-supporting.

More technical exhibit space was sold than for the past several years, and a large number of excellent informative scientific exhibits were displayed. For the third year, the Woman's Auxiliary arranged an Art and Hobby Show, which continues to create much interest.

Plans are practically complete for the 1973 Semiannual Meeting in Mexico City where the daily scientific sessions will be held at the world-renowned Instituto Nacional de Cardiologia. This will be followed by a post-convention trip to Acapulco. The response from the members of the Faculty to this Semiannual Meeting has been exceptionally good.

On behalf of the President, Dr DeLawter, and our Committee, I extend most sincere thanks to everyone

involved in making these meetings so successful: members of the Faculty, specialty societies, medical assistants, Woman's Auxiliary, and the staff of the Faculty.

Particular appreciation must go to Mrs Genevieve Ritchie, of the Faculty staff. Few people realize the tremendous detail and grasp of the problems involved in presenting the annual and semiannual meetings. Without her assistance, knowledge of these details, and her quick grasp of problems—anticipating them before they occur—we could have had chaos. Our sincere thanks to her.

Respectfully submitted,

ALBERT M ANTLITZ MD, Chairman
JAMES D DRINKARD MD
EDWIN H STEWART JR MD
JOHN H TUOHY MD
GEORGE D YENT JR DDS
MRS MARVIN L KOLKIN

Subcommittee on Exhibits:

JAMES D DRINKARD MD, Chairman
EDWIN H STEWART JR MD
NORVAL D HAUGH
GORDON WEHRLE

Subcommittee on Health Evaluation Tests:

ROBERT E WENK MD, Chairman
FREDERICK W BAUER MD
BERNARD TABATZNIK MD
FRANK L ANGELL MD
STEPHEN B HAMEROFF MD
DOROTHY HARTEL

Subcommittee on Art and Hobby Exhibit:

MRS FERD E KADAN, CoChairman
MRS WILLIAM ROEMMICH, CoChairman

PUBLIC RELATIONS COMMITTEE

Mr President and Members of the House of Delegates:

Six meetings were held during the year which has been an active one. Probably the most significant achievement has been the employment of a Public Relations Consultant approved by the Council with an expenditure of up to \$15,000 for the calendar year 1973. James Holechek Associates was engaged after a review of several other bids. The proposal submitted by Mr Holechek was reviewed and approved by the Committee and work started immediately.

News releases have been prepared on items of timely interest, and feature articles prepared. Several radio tapes have been prepared to be used by local radio stations on public service time. A television series produced by the Los Angeles County Medical Society was reviewed and approved for showing locally, depending on ability of the producers to obtain funding for distribution. Council approved a pledge of \$1,000 as token of interest in order to support the seeking of a grant to distribute these films. At this writing, no definite information has been received as to the success of this venture.

Component societies have been requested to designate a public relations representative in order that information may be exchanged and the benefits of the public relations consultant spread throughout the State.

Action '72 program was initiated at the request of the AMA. This is an informative and educational program, designed to keep physicians informed as to the good and bad points of the various national health insurance programs. After establishing a Task Force to assist in this educational process, the chairman visited three county

societies. It is hoped that other counties will take advantage of the opportunity to learn more about this very important issue. The AMA field staff has been helpful in this regard.

The recent publicity and controversy over the approval for the building of a community hospital in Howard County has given rise to great concern by physicians, not only of that county but throughout the State. The chairman was designated as Faculty spokesman at meetings with the Comprehensive Health Planning Agency in order to make clear the position of the Faculty in certain aspects of this controversy. Although no concrete changes were made as a result of this representation it is believed that a clearer line of communication has been opened between the CHPA and the Faculty which should prove useful in future health planning.

The planned *Baltimore News American* Supplement has been canceled due to failure on the part of the *News American* to obtain sufficient advertising coverage. Articles written by several physicians for this supplement will be used as feature articles from time to time.

Three Medical Assistants' Seminars were held during the year: one each in Washington County, Baltimore City,

and Montgomery County. These seminars continue to be received with enthusiasm and will continue as a public relations program. In addition, a public speaking seminar is planned for the fall of 1973.

Many other projects are in the planning stage and the Committee continues to look for new ways to improve the "image" of the physician and of the medical society.

The Woman's Auxiliary continued its usual active role in many areas. We are indebted to this dedicated group for its continuing support and activities in the community on behalf of the medical profession.

Respectfully submitted,

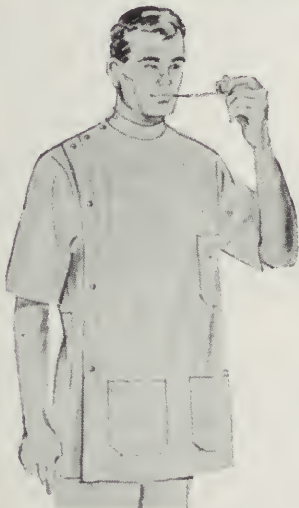
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REFERENCE COMMITTEE

Mr President and Members of the House of Delegates:

Your Reference Committee met at a publicly announced session on Thursday March 29, 1973 to consider the five resolutions introduced prior to the deadline of Friday, March 2, 1973 for introduction of resolutions.

This year, an exceptionally large group of members showed up for discussion of the resolutions. Unfortunately, sponsors of three of the resolutions had no representative to speak for their proposals. The Reference Committee deplors this lack of interest and believes the House of Delegates should give some consideration to automatic rejection of a resolution when this occurs. The Committee has no recommendation in this regard, however.

As is the custom, actions of the House of Delegates will be on the Resolutions, themselves, not on the Reference Committee's recommendations.

Resolution 1A/73

WHEREAS, The day has long since passed when there were second-class citizens in our society; and

WHEREAS, There is and should be only one brand of medicine, the best possible, practiced in this state; and

WHEREAS, The Maryland Medicaid fee schedule is based on the premise of the second-class medical citizen; and

WHEREAS, The Medicaid patient often has very limited or no freedom of choice in his selection of a physician due to this discrepancy; and

WHEREAS, Our neighboring states of Delaware and Virginia have corrected this iniquity by adopting a "usual and customary" fee schedule for their state-aid patients; be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland do everything in its power to effect changes in the Medicaid program so there will no longer be second-class medical citizens in Maryland.

Your Reference Committee is of the opinion that this resolution implies Medicaid recipients are receiving second-class medical care. It does not believe this is so.

The Committee is also of the opinion that the Faculty has on many different occasions reiterated the policy that Usual, Customary and Reasonable Fees be paid by governmental agencies, whether they be Medicaid, Workmen's Compensation, Vocational Rehabilitation clients, or others.

No person at the Reference Committee spoke in support of this resolution, although several spoke against it.

Faculty Committees, officers, and staff are continually negotiating this problem and the Reference Committee believes that it does no harm to again restate policy in this regard. However, it is recommended that the following substitute Resolved be adopted:

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland do everything in its power to effect changes in Maryland's Medicaid program to accomplish the objective that Usual, Customary and Reasonable fees be paid under the State's Medicaid program.

Resolution 2A/73

WHEREAS, The majority of the members of the Medical and Chirurgical Faculty of the State of Maryland live in the vicinity of Baltimore City; and

WHEREAS, The center of medical activity in the State is the City of Baltimore where the two medical schools are located; and

WHEREAS, The Mayor of the City of Baltimore has assured the Baltimore City Medical Society that he is pre-

pared to use necessary City resources to solve problems of parking and additional space; and

WHEREAS, The members of the Baltimore City Medical Society, at its General Meeting held Feb 1, 1973, unanimously adopted a resolution opposing the move of the headquarters and library of the Medical and Chirurgical Faculty of the State of Maryland from Baltimore City and directing that a resolution to this effect be introduced and supported by the Baltimore City Medical Society Delegates at the 175th Annual Meeting of the Medical and Chirurgical Faculty House of Delegates in April 1973; be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland opposes the move of the headquarters and library of the Medical and Chirurgical Faculty of the State of Maryland from the City of Baltimore; and be it further,

Resolved, That the appropriate authorities in the Medical and Chirurgical Faculty of the State of Maryland be directed to contact the Mayor of The City of Baltimore to discuss the availability of space in Baltimore City which would provide adequate office space and parking space to house the headquarters and library.

Your Reference Committee heard from witnesses that negotiations are already under way with the Mayor of Baltimore City and that considerable progress has been made in this connection. It believes that adoption or rejection of this resolution at this time might have a deleterious effect on such discussions.

The Reference Committee wishes to point out that this House of Delegates must take action to approve any relocation of the Faculty headquarters; for any construction program; or for any action with a magnitude of this nature. There is no record of this House having approved any such program. The only action taken was approval of the purchase of land in Howard County. This has been accomplished and is held as an investment, similar to other investments held in the Faculty portfolio.

Your Reference Committee recommends that Resolution 2A/73 be referred to the Ad Hoc Building Committee for its information and report to the Semiannual Meeting of the House of Delegates on Sept 15, 1973.

Resolution 3A/73

WHEREAS, Medical care throughout the State of Maryland is generally rendered by well trained physicians; and

WHEREAS, The cost of living differential in different areas of the State is essentially the same; and

WHEREAS, The cost of Maryland Blue Shield, Medicare, and other forms of insurance for the payment of physician's services is the same throughout the State of Maryland; and

WHEREAS, Labor Unions of this nation have established equal pay for equal work regulations; and

WHEREAS, The Maryland Blue Shield, Medicare, and other third-party payors continue to differentiate their reimbursement formulae on a regional basis; and

WHEREAS, Such regionalization of physician reimbursement is unfair to physicians practicing in the nonmetropolitan areas of the State; be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland on behalf of the practicing physicians of Maryland file a class action suit against all third-party payors, especially Maryland Blue Shield and the Social Security Administration, to cause them to equalize physician reimbursement formulae so that all physicians of the State are paid a fair and equal fee for professional services.

Again your Reference Committee heard no comments on this resolution, either pro or con. It was mentioned that the word "equalize" could be interpreted to mean a reduction of fees currently paid, to the lowest amount paid in the State. It was also mentioned that this resolution would eliminate the profiles currently maintained by third-party carriers.

Your Reference Committee was informed by staff that the cost of such class action suits could be in the thousands of dollars, if not in the tens of thousands of dollars. It believes no useful purpose could be served by the filing of such a class action suit.

Your Reference Committee recommends that Resolution 3A/73 **NOT** be adopted.

Resolution 4A/73

WHEREAS, The Medical and Chirurgical Faculty of the State of Maryland is gradually increasing its services and activities to the members and to the citizens of the State of Maryland; and

WHEREAS, The office space available in the Faculty Building is congested and overcrowded; and

WHEREAS, There are no plans for expansion at this time; be it

Resolved, That the Medical and Chirurgical Faculty discontinue the rental of office space to other than State level organizations, except for meetings, after Dec 31, 1974.

Here, again, no person spoke in support of this resolution. Representatives of the Baltimore City Medical Society indicated willingness on the part of that group to relocate from the Faculty Building. Adoption of the resolution would also affect the Baltimore City Dental Society.

The space occupied by these two organizations is insufficient to resolve the problem of cramped quarters for the administrative staff of the Faculty. It also noted that negotiations are taking place with the Mayor's office of Baltimore City and that recommendations for resolution of the space problems mentioned in the resolution may be forthcoming in the near future.

Your Reference Committee recommends that Resolution 4A/73 **NOT** be adopted.

Resolution 5A/73

WHEREAS, There is great public concern over members of hospital boards being involved in a conflict of interest; and

WHEREAS, This concern is also expressed in other areas such as legislative, political, and related fields; and

WHEREAS, This is a proper concern by the Faculty because individuals should not be placed in a position of having to make a choice with respect to the area in which their loyalties lie; and

WHEREAS, On occasion, despite attempts to be completely neutral, elected officials of the Faculty may be directly involved in a conflict of interest situation; and

WHEREAS, There have been some members of the Faculty who have expressed concern that their best interests and the best interests of the practicing physician community may not be represented by individuals holding elective positions in the Faculty while at the same time acting in a fiduciary capacity on policy making bodies for third-party insurance carriers or government agencies; be it

Resolved, That it be the policy of the Medical and Chirurgical Faculty of the State of Maryland that elected officials of the Faculty who act in a fiduciary capacity or in policy making decisions for third-party insurance car-

riers or governmental agencies exclude themselves from policy or other decisions of the Faculty whenever such a conflict of interest might arise.

Your Reference Committee heard testimony in support of this resolution but failed to receive answers as to what was specifically meant by "conflict of interest." Varying interpretations were provided by attendees at the meeting, and it was obvious that this meant different things to different persons.

"Robert's Rules of Order Newly Revised" governs the conduct of all meetings where no other policy is established. (Article XV of the Faculty Bylaws). This Authority provides that whenever a conflict of interest arises with an individual, be he an officer or other representative, he should exclude himself from the vote on that issue.

Your Reference Committee believes this is sufficient for policy of the Faculty. It, therefore, recommends that Resolution 5A/73 **NOT** be adopted.

It was brought to the attention of the Committee that two resolutions were received in the Faculty office after the deadline for receipt of such resolutions. All members of the House and Component Society Officers are reminded, again, of the deadline for receipt of resolutions to be considered at the Annual and Semiannual meetings. This is eight weeks prior to the meeting date.

Respectfully submitted,

Herbert H Leighton MD, Garrett County, Chairman
Melvin B Davis MD, Baltimore County
Marvin I Mones MD, Montgomery County
Andrew C Mitchell MD, Wicomico County
Louis L Randall MD, Baltimore City

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SECRETARY

Mr President and Members of the House of Delegates:

The growth in Faculty membership continues, as it now totals nearly 4,500.

The Secretary is responsible for the maintenance of records, for correspondence, and for overseeing the total operation of the Faculty administrative staff. His job is made easy by those persons working for the Faculty who give total dedication to their work. Committee minutes, correspondence, and other work emanating from committee actions; contact with the public, individual members, component medical societies and allied health groups are all handled on an efficient and workmanlike basis. Those on the outside are not fully aware of the tremendous volume of work that is carried out day by day on behalf of the total membership.

This report would not be complete without a word of thanks to committee chairmen and members; to those persons who serve without recompense on the Executive Committee and Council, and to those who give in the thousands of other ways to exemplify the highest traditions of the profession.

Respectfully submitted,

WILLIAM A PILLSBURY MD, Secretary

SPECIAL COMMITTEES

AD HOC FACULTY BUILDING COMMITTEE

Mr President and Members of the House of Delegates:

Approval given to purchase of up to 20 acres of land in Howard County by the House of Delegates at the 1972 Annual Meeting has been consummated. However, the purchase of this land has led to the belief that the Faculty is planning to move its headquarters and construct a new building at this location. Any such action would have to be approved by the House of Delegates. There has been no such recommendation made in this regard.

Conversations have been held with the Mayor of the City of Baltimore who has pledged his assistance and full cooperation in doing all he can to provide space in the City suitable for any expansion of our present, overcrowded facility. It is anticipated that a further report will be made at a future meeting of the House of Delegates in this regard.

Respectfully submitted,

RUSSELL S FISHER MD, Chairman

M MCKENDREE BOYER MD

HENRY A BRIELE MD

A C DICK MD

E W DITTO JR MD

NOTES TO FINANCIAL STATEMENTS

Note 1—Summary of Significant Accounting Policies


The Medical and Chirurgical Faculty of the State of Maryland is a nonprofit organization, tax exempt under Section 501 of the Internal Revenue Code, and accordingly employs accounting practices generally followed by nonprofit organizations.

Fixed assets, other than personal property, are recorded at cost. Portraits were appraised as of Dec 31, 1963 at \$65,000.00, an increase of \$51,000.00 over prior years. All other personal property was appraised as of Dec 31, 1949, with subsequent additions at cost. Depreciation on fixed assets is not provided.

Income and expenses are recorded on the accrual basis.

Note 2—On Dec 29, 1972, the Faculty entered into an agreement with Bon Secours Hospital Inc to purchase 20 acres of land located in Howard County.

The purchase price for the property is \$200,600, of which \$100,000 has been deposited, leaving a balance of \$100,600 together with any and all other adjustments or costs, to be paid at the time of settlement, on or before April 1, 1973.



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JAMES R KARNES MD

W J McCLAFFERTY MD

TREASURER

Mr President and Members of the House of Delegates:

The annual audit of the records of the Medical and Chirurgical Faculty of the State of Maryland has been completed. The financial statements reflecting the results of operations of the year 1972 and the financial position of the Faculty are part of this report.

The 1973 Budget was approved by the Council. You will note that it is a balanced budget and is the result of careful consideration at several budget meetings.

Respectfully submitted,

KARL F MECH MD, Treasurer

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He has Trichomonas vaginalis?

It's his infection but her problem...

Men with trichomonal infection are virtually always asymptomatic, which is why they seldom know they have the disease. But many do have it, nevertheless.

Trichomonal infection is so common that estimates¹ indicate one out of every four women of reproductive age has the disease. *Almost half of the husbands of women infected with Trichomonas vaginalis have it, too.*²⁻⁹

CONCURRENT THERAPY WITH FLAGYL PROVIDES ALMOST CERTAIN CURE FOR BOTH OF THEM.

- It is the most effective drug available for the treatment of trichomoniasis in both men and women.
- In men, it eliminates infection from the genitourinary tract.
- In women, it eliminates trichomonal infection from the vagina, the paravaginal crypts, cavities, and glands.
- Consistent cure rates above 90 percent are to be expected. The rate often approaches 100 percent.
- Simple, sure treatment for women: One 250-mg. tablet three times daily for ten days.
- Simple, sure treatment for men: One 250-mg. tablet twice daily for ten days concurrent with treatment of the female partner.
- Side effects are generally mild and infrequent.
- Flagyl is economical because it is so effective.

Flagyl[®] can cure them both. (metronidazole)

Indications: For the treatment of trichomoniasis in both male and female patients and in the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture. The oral tablets are indicated also for acute intestinal amebiasis (amebic dysentery) and amebic liver abscess.

Contraindications: Evidence or history of blood dyscrasia, active organic disease of the CNS, the first trimester of pregnancy and a history of hypersensitivity to metronidazole.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differen-

tial leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the

mouth, vagina or vulva, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. Flattening of the T wave may be seen in ECG tracings.

Dosage and Administration: For Trichomoniasis. In the female: One 250-mg. tablet orally three times daily for ten days. Course may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during, and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used, one 500-mg. insert is placed high*



in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the male:* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

For Amebiasis. *Adults:* For acute intestinal amebiasis, 750 mg. orally three times daily for 5 to 10 days. For amebic liver abscess, 500 to 750 mg. orally three times daily for 5 to 10 days. *Children:* 35 to 50 mg./kg. of body weight/24 hours, divided into three doses, orally for ten days.

Dosage forms: Oral tablets 250 mg.
Vaginal inserts 500 mg.

References:

1. Perl, G., and Ragazzoni, H.: Flagyl in Treatment of "Trichomonas Vaginalis" Vaginitis, *Obstet. Gynecol.* 19:595-598 (May) 1962. 2. Kean, B. H.: Trichomoniasis in Males (Letters to the Journal), *J. A. M. A.* 186:273 (Oct. 19) 1963. 3. King, A. J.: Current Therapeutics: CLVI.—Metronidazole in the Treatment of Trichomonal Infections, *Practitioner* 185:808-812 (Dec.) 1960. 4. Watt, L., and Jennison, R. F.: Clinical Evaluation of Metronidazole: A New Systemic Trichomonacide, *Br. Med. J.* 2:902-905 (Sept. 24) 1960. 5. Watt, L., and Jennison, R. F.: Metronidazole Treatment of Trichomoniasis in the Female, *Br. Med. J.* 1:276-279 (Feb. 3) 1962. 6. Teton, J. B., and Treadwell, N. C.: Evaluation of a Systemic Trichomonacide, *Obstet. Gynecol.* 21:356-362 (March) 1963. 7. Durel, P.; Roiron, V.; Siboulet, A., and Borel, L. J.: Systemic Treatment of Human Trichomoniasis with a Derivative of Nitro-Imidazole, 8823 R. E. Br. J. Vener.

Dis. 36:21-26 (March) 1960. 8. Bertrand, P., and Leulier, J.: Essais cliniques sur la trichomonase des partenaires des femmes infestées (Proceedings of the 1st Canadian Symposium on Non-Gonococcal Urethritis and Human Trichomoniasis, Montreal, 1959), *Gynaecologia* 149:93-96 (Suppl.) 1960. 9. Poole-Wilson, D. S.: The Diagnosis and Management of Chronic Infection of the Bladder, *Practitioner* 186:429-437 (April) 1961.

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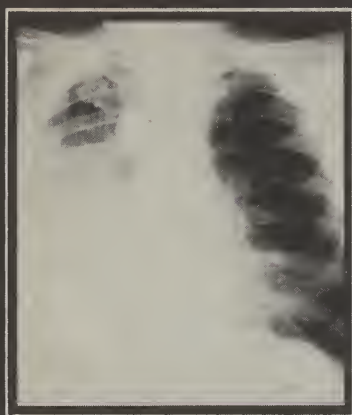
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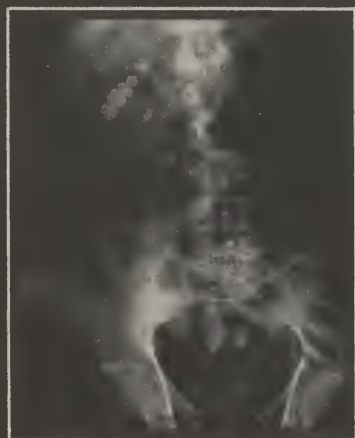
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restricted by state law); by
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64.8 mg. (gr. 1). *Warning—
may be habit-forming. Each
tablet also contains: aspirin
gr. 3 1/2, phenacetin gr. 2 1/2,
caffeine gr. 1/2.



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ANNUAL FINANCIAL STATEMENTS

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

WOODEN & BENSON

CERTIFIED PUBLIC ACCOUNTANTS

Members American Institute of Certified Public Accountants
Maryland Trust Building

BALTIMORE, MARYLAND 21202

301-752-4860

The Medical and Chirurgical Faculty
of the State of Maryland
1211 Cathedral St
Baltimore Md 21201

ACCOUNTANTS' REPORT

We have examined the balance sheet of the Medical and Chirurgical Faculty of the State of Maryland as of Dec 31, 1972 and the related statements of income, expenses and transfers, statement of income, expenses and appropriations, and statements of capital for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of the Medical and Chirurgical Faculty of the State of Maryland as of Dec 31, 1972 and the results from operations for the year then ended, in conformity with generally accepted accounting principles, applied on a basis consistent with that of the preceding year.

/s/ WOODEN & BENSON

March 16, 1973

AUGUST 1973

1973 ESTIMATED EXPENDITURES

	Budget 1972	Actual through November	Budget 1973
Auditing	\$ 3,000.00	\$ 2,851.00	\$ 3,000.00
Legal	10,000.00	9,650.00	13,000.00
Contributions	1,000.00	550.00	1,000.00 A*
Fuel	2,500.00	1,714.00	2,500.00
Gas, Electricity, Water	6,500.00	5,448.00	6,500.00
Telephone & Telegraph	6,500.00	6,011.00	6,500.00
Postage	7,500.00	5,948.00	7,700.00
Household & Janitorial	2,500.00	1,630.00	2,000.00
Property Maintenance	4,000.00	2,794.00	4,000.00
Insurance	2,000.00	2,118.00	2,500.00
Special Equipment Services	5,000.00	5,261.00	6,000.00
New Equipment	2,000.00	574.00	1,000.00
Equipment Maintenance	1,500.00	1,158.00	1,500.00
Stationery & Supplies	4,000.00	2,135.00	3,000.00
Salaries	227,658.00	209,745.00	241,069.00 B*
Social Security	9,500.00	8,719.00	12,151.00
Unemployment Compensation	1,500.00	1,024.00	2,000.00
Employees' Insurance Program	4,000.00	5,369.00	6,000.00
Employees' Pension Program	12,000.00	17,663.00	15,000.00
Supplementary Hours Exp	2,500.00	2,325.00	2,500.00
Travel	12,000.00	9,240.00	12,000.00 C*
Printing	11,500.00	6,953.00	10,000.00 D*
Data Processing-Membership Records	3,000.00	902.00	2,000.00
Legislation	7,000.00	6,081.00	7,000.00
Library	5,247.00	3,926.00	5,364.00 E*
Journal Expense	80,000.00	63,395.00	70,000.00
Annual & Semiannual Meetings	27,000.00	35,590.00	30,000.00
Presidential Fund	1,000.00	-0-	1,000.00
Woman's Auxiliary	1,000.00	1,000.00	1,000.00
Miscellaneous Expenses	3,000.00	3,787.00	3,000.00
TOTAL	\$465,905.00	\$423,561.00	\$480,284.00

* See Explanatory Notes

1973 BUDGET NOTES

A. CONTRIBUTIONS:

Reflects a reserve for possible requests during the year.
Budgeted items include:

Student American Medical Association:

National Chapter	\$100.00
University of Maryland Chapter	450.00
Johns Hopkins Chapter	50.00
Miscellaneous	400.00
	<u>\$1,000.00</u>

B. SALARIES:

Includes \$35,857.00 which is offset by payments from the Baltimore City Medical Society and the Med-Chi Insurance Trust, as shown in Estimated Income.

C. TRAVEL:

The following is included:

National Leadership Conference, Chicago, two days, Feb 16-17, President and one staff member.

Medicolegal Symposium, Las Vegas, March 22-25, one staff member.

Socio-Economics of Health Care, Chicago, April 13-15, one staff member.

AMA Annual Convention and Medical Society Executives Association, New York City, June 25-30, three Delegates, three Alternate Delegates, President, and one staff member.

AMA Clinical Session and Medical Society Executives Association, Anaheim Calif, three Delegates, three Alternate Delegates, President, and one staff member.

D. PRINTING:

Includes the publication cost of the membership directory.

E. LIBRARY:

Includes Memberships, Travel, Supplies, Equipment, Photocopying, Postage, and Miscellaneous Library expenditures. Library salaries are in the Salary account. Journal subscriptions, books, binding, etc are purchased by designated funds and are not included in this item.

1973 ESTIMATED INCOME

	1972 THROUGH NOVEMBER	1973 BUDGET
DUES		
Component Society Members	\$342,205.00	\$342,000.00
Baltimore City Dental Society	1,745.00	1,950.00
	343,950.00	343,950.00
RENTS & SERVICES		
Baltimore City Medical Society	24,000.00	31,795.00
Board of Medical Examiners	6,450.00	6,900.00
Maryland League for Nursing	385.00	420.00
Med-Chi Insurance Trust	13,451.00	14,191.00
Educational Fund	—0—	4,200.00
	44,286.00	57,506.00
INVESTMENT INCOME		
Restricted Fund Earnings	4,362.00	4,400.00
Short-term Interest	5,878.00	6,000.00
	10,240.00	10,400.00
MEDICAL JOURNAL	44,419.00	50,000.00
ANNUAL & SEMIANNUAL MEETINGS	21,058.00	21,000.00
OTHER	2,452.00	2,000.00
TOTAL	\$466,405.00	\$484,856.00

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THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

Baltimore, Maryland

BALANCE SHEET—ALL FUNDS—DEC 31, 1972

ASSETS

CASH		
Maryland National Bank		
Operating	159,180.04	
Payroll	7,054.82	
Savings account	31,433.18	
Petty cash funds	400.00	
Short-term Investment at Cost Plus Accrued Interest	198,068.04	
	99,156.42	
ACCOUNTS RECEIVABLE		
Memberships dues, journal advertising, etc.	13,098.28	
Due from Other Funds		
Steiner Fund	694.45	
Med-Chi Insurance Trust Fund	1,331.77	
Loan Receivable—Plant Fund	15,124.50	
	63,090.23	
DEFERRED EXPENSES		
Air Travel	425.00	
Insurance premiums	1,712.91	
Other	250.00	
TOTAL GENERAL FUND	2,387.91	
	377,827.10	
LIABILITIES		
Accounts Payable		
Trade		4,703.77
American Medical Association—dues collected		72,315.00
Component Societies—dues collected		44,424.00
Due to other Funds		
Educational fund	10,954.75	
Consolidated fund (Ruhrah)	3,096.56	
		14,051.31
Payroll taxes		135,494.08
Accrued expenses—insurance and pension		3,187.06
Designated		467.00
Library account—books and journals		3,231.01
Educational—assessments collected		22,935.00
		26,166.01
Deferred Income		
Memberships pending election		2,865.00
Dues—1973		87,220.00
		90,085.00
Capital—Exhibit C		255,399.15
		122,427.95
TOTAL GENERAL FUND	377,827.10	

LIABILITIES AND CAPITAL

GENERAL FUND

ENDOWMENT AND OTHER SPECIAL FUNDS

Consolidated Fund—Exhibit A-1	452,051.15	Consolidated Fund—Income and Principal Accounts—Exhibit A-1	452,051.15
Funded Reserve—Exhibit A-2	25,186.63	Funded Reserve—Income and Principal Accounts—Exhibit A-2	25,186.63
Harvey G Beck—Lectureship Fund—Exhibit A-3	2,837.16	Harvey G Beck—Income and Principal Accounts—Lectureship Fund—Exhibit A-3	2,837.16
Jesse C Coggins Funds		Jesse C Coggins Funds	
Lectureship—Cash—Maryland National Bank	5,564.62	Lectureship—Capital—Exhibit J	5,564.62
New Building—Exhibit A-4	155,999.96	New Building—Capital—Exhibit A-4	155,999.96
	161,564.58		161,564.58
George M Boyer—Lectureship Fund		George M Boyer—Lectureship Fund	
Cash—Loyola Federal Savings and Loan Association	5,561.43	Capital	5,561.43
Amos Koontz—Memorial Fund—Exhibit A-5	2,551.95	Amos Koontz—Memorial Fund—Capital—Exhibit A-5	2,551.95

BALANCE SHEET—DEC 31, 1972**CONSOLIDATED FUND****ASSETS****INCOME ACCOUNT**

Cash—The Savings Bank of Baltimore—Exhibit F			
Eugene Cordell Fund	13,940.70		
Special accounts	<u>20,703.91</u>	34,644.61	
Accounts receivable—general fund (Ruhrah)		3,096.56	
Investments			
Eugene Cordell Fund—Held by Maryland			
National Bank—Agent—Exhibit F			
Cash	(27.16)		
Common stocks—Schedule A-4	<u>23,587.16</u>	<u>23,560.00</u>	61,301.17

PRINCIPAL ACCOUNT

Held by Maryland National Bank—			
Agent—Schedule A-1			
Cash		3,102.64	
Investments—at cost			
Bonds			
United States Government	3,578.75		
Others	<u>120,471.20</u>	124,049.95	
Stocks			
Common		<u>263,597.39</u>	390,749.98

TOTAL—INCOME AND PRINCIPAL ACCOUNTS

Assets—To Exhibit A			<u>452,051.15</u>
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LIABILITIES AND CAPITAL**INCOME ACCOUNT**

Capital—Exhibit E			61,301.17
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PRINCIPAL ACCOUNT

Capital—Exhibit G			<u>390,749.98</u>
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TOTAL—INCOME AND PRINCIPAL ACCOUNTS—

Liabilities and Capital—To Exhibit A			<u>452,051.15</u>
--	--	--	-------------------

Exhibit A-2

BALANCE SHEET—DEC 31, 1972**FUNDED RESERVE****ASSETS****INCOME ACCOUNT**

Cash—Savings Bank of Baltimore			7,362.95
--------------------------------------	--	--	----------

PRINCIPAL ACCOUNT

Investments—Held by Maryland National Bank—Agent			
Cash		867.15	
Common stock—Schedule A-4		<u>16,956.53</u>	<u>17,823.68</u>

TOTAL—INCOME AND PRINCIPAL ACCOUNTS—

Assets—to Exhibit A			<u>25,186.63</u>
---------------------------	--	--	------------------

LIABILITIES AND CAPITAL**INCOME ACCOUNT**

Capital—Exhibit H			7,362.95
-------------------------	--	--	----------

PRINCIPAL ACCOUNT

Capital—Exhibit H			<u>17,823.68</u>
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TOTAL—INCOME AND PRINCIPAL ACCOUNTS—

Liabilities and Capital—To Exhibit A			<u>25,186.63</u>
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BALANCE SHEET—DEC 31, 1972
HARVEY G BECK—LECTURESHIP FUND

ASSETS

INCOME ACCOUNT		
Cash—Savings Bank of Baltimore		677.35
PRINCIPAL ACCOUNT		
Investments—Held by Maryland National Bank—Agent		
Cash	190.07	
Common stock—Schedule A-4	1,969.74	2,159.81
TOTAL—INCOME AND PRINCIPAL ACCOUNTS		
Assets—To Exhibit A		<u>2,837.16</u>

LIABILITIES AND CAPITAL

INCOME ACCOUNT		
Capital—Exhibit I		677.35
PRINCIPAL ACCOUNT		
Capital—Exhibit I		2,159.81
TOTAL—INCOME AND PRINCIPAL ACCOUNTS—		
Liabilities and Capital—To Exhibit A		<u>2,837.16</u>

Exhibit A-4

BALANCE SHEET—DEC 31, 1972
JESSE C COGGINS—NEW BUILDING FUND

ASSETS

PRINCIPAL ACCOUNT		
Cash—Loyola Federal Savings and Loan Association	37,255.08	
—Maryland National Bank	29,811.86	67,066.94
Account receivable—due from plant fund		45,033.02
Investments—at cost—Schedule A-4		43,900.00
TOTAL—PRINCIPAL ACCOUNT—Assets—To Exhibit A		<u>155,999.96</u>

LIABILITIES AND CAPITAL

PRINCIPAL ACCOUNT		
Capital—Exhibit Q		155,999.96
TOTAL—PRINCIPAL ACCOUNT		
Liabilities and Capital— To Exhibit A		<u>155,999.96</u>

Exhibit A-5

BALANCE SHEET—DEC 31, 1972
AMOS KOONTZ—MEMORIAL FUND

ASSETS

Cash—Loyola Federal Savings and Loan Association	2,551.95	
TOTAL—Assets—To Exhibit A		<u>2,551.95</u>

LIABILITIES AND CAPITAL

Capital—Exhibit K	2,551.95	
TOTAL—Liabilities and Capital—To Exhibit A		<u>2,551.95</u>

BALANCE SHEET—DEC 31, 1972
EDUCATIONAL FUND

ASSETS

Cash—Maryland National Bank—Savings Account	2,338.21
Due from General Fund	10,954.75
TOTAL—Assets—To Exhibit A	13,292.96

LIABILITIES AND CAPITAL

Capital—Exhibit L	13,292.96
TOTAL—Liabilities and Capital—To Exhibit A	13,292.96

Exhibit A-7

BALANCE SHEET—DEC 31, 1972
LEWIS HENRY STEINER FUND

ASSETS

INCOME ACCOUNT	
Cash—Savings Bank of Baltimore	28,397.25
PRINCIPAL ACCOUNT	
Uninvested cash—Maryland National Bank	(64.22)
Due from income account—contra	5,160.41
Investments—at cost—Schedule A-7	365,744.86
Total Principal Account—Assets	370,841.05
GRAND TOTAL—INCOME AND PRINCIPAL ACCOUNT	
Assets—To Exhibit A	399,238.30

LIABILITIES AND CAPITAL

INCOME ACCOUNTS	
Liabilities	
Due to general fund for expenditures	694.45
Due to principal account—contra	5,160.41
Capital—Exhibit N	22,542.39
Total Income Account—Liabilities and Capital	28,397.25
PRINCIPAL ACCOUNT	
Capital—Exhibit N	370,841.05
GRAND TOTAL—INCOME AND PRINCIPAL ACCOUNT	
Liabilities and Capital—To Exhibit A	399,238.30

Exhibit C

STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
GENERAL FUND

Jan 1, 1972—Balance	105,643.94
Deduction	
Excess of income and transfers over expenses—Exhibit B	16,784.01
Jan 1, 1972—Balance	122,427.95

STATEMENT OF INCOME, EXPENSES AND TRANSFERS
FOR YEAR ENDED DEC 31, 1972
GENERAL FUND

INCOME

Dues—Baltimore City Dental Society	1,745.00	
County Medical Societies	342,185.00	343,930.00
Rents and Services		
Baltimore City Medical Society	27,912.00	
Others	7,530.00	35,442.00
Meetings—annual and semiannual exhibits		21,058.00
Journal—advertising	51,598.26	
—subscriptions	2,745.86	54,344.12
Addressograph services		1,628.62
Interest on savings accounts		7,689.39
Miscellaneous		1,490.54
		465,582.67
Transfer from consolidated fund—income for general purposes—Exhibit F		5,020.25
TOTAL INCOME AND TRANSFERS—Forwarded		470,602.92

EXPENSES

Accounting fees	2,351.40	
Communication—postage, telephone, and telegraph	10,945.61	
Contributions	550.00	
Equipment rental and maintenance	7,231.96	
Fuel	2,325.60	
Gas, electricity, and water	6,007.31	
Household and janitorial services	1,656.13	
Insurance—general	2,535.62	
—employee benefits	6,495.44	
Journal expenses—printing and commissions	71,989.67	
Legal fees	10,225.00	
Legislature	6,080.65	
Library	4,475.81	
Meetings—annual and semiannual	36,014.75	
Data processing—memberships	1,626.23	
Office supplies	2,186.39	
Pension and major medical contribution	18,067.09	
Printing	8,878.82	
Purchase of equipment	574.20	
Property maintenance	2,989.81	
Salaries	215,535.67	
Social security	10,054.93	
Supplementary hours	2,755.43	
Travel	11,649.32	
Unemployment insurance—Federal	614.00	
—State	707.10	
Women's auxillary	1,000.00	
Foundation	4,013.52	
Miscellaneous	4,281.45	
TOTAL EXPENSES		453,818.91
EXCESS OF INCOME AND TRANSFERS OVER EXPENSES—To Exhibit C		16,784.01

**STATEMENT OF INCOME, EXPENSES AND APPROPRIATIONS
FOR YEAR ENDED DEC 31, 1972
CONSOLIDATED FUND—INCOME ACCOUNT**

INCOME

Distributive Share—Exhibit F			
Bonds—Schedule A-1			
United States Government	122.50		
Others	5,989.50	6,112.00	
Stocks—Schedule A-1			
Preferred	229.00		
Common	13,266.66		
Less—direct share—			
Charles M Ellis Fund	2,377.50	10,889.16	11,118.16
Interest on special savings account—			
The Savings Bank of Baltimore—			
Schedule A-1		2,127.50	
		19,357.66	
Less—agency fees		4,548.17	14,809.49
Direct Share—Exhibit F			
Charles M Ellis Fund—common stock		2,377.50	
Investments—Eugene F Cordell Fund			
Stocks and Bonds—Schedule A-4			
Common	242.40		
Bond	712.50		
	954.90		
Less—agency fees	57.30	897.60	
Loss on sale of securities—			
Schedule A-4	(1,899.44)	(1,001.84)	1,375.66
Other Income—Exhibit F			
Interest on Savings Account			
Eugene F Cordell Fund—			
The Savings Bank of Baltimore			636.12
			16,821.27
EXPENSES AND APPROPRIATIONS—Exhibit F			
Library—general		8,287.92	
Library payroll, maintenance, etc, transferred to general fund		5,020.25	
Lectureship		1,715.38	
Cordell Fund		2,400.00	17,423.55
EXCESS OF EXPENSES AND APPROPRIATIONS OVER INCOME—			
To Exhibit E			602.28

Exhibit E

**STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
CONSOLIDATED FUND—INCOME ACCOUNT**

Jan 1, 1972—Balance—Exhibit F	61,903.45
Deduction	
Excess of expenses and appropriations over income—Exhibit D	602.28
Dec 31, 1972—Balance—To Exhibits A-1 and F	61,301.17

**STATEMENT OF RECEIPTS, EXPENSES AND BALANCES
FOR YEAR ENDED DEC 31, 1972
CONSOLIDATED FUND—INCOME ACCOUNT**

Fund	Distribu- tive Share (Percent)	Balance Jan 1, 1972	Income Received During Year			Balance Jan 1, 1972 Plus Receipts	Expenses			Balance Dec 31, 1972		
			Investment Income		Other Income		Library	Trans- ferred to General Fund (Exhibit B)	Lecture- ship	Other	Fund Balance	Cash on Deposit
			Distribu- tive Share	Direct Share								
Baker .....	.65	280.93	96.26			377.19	63.68				313.51	
Barker, Lewellyn F .....	.39	219.61	57.76			277.37					277.37	
Bowen, Josiah S	9.17	—	1,358.03			1,358.03		1,358.03			—	
Bressler, Frank C	1.80	—	266.57			266.57		266.57			—	
Cordell, Eugene												
Fauntleroy	3.64	36,072.44	539.07	(1,001.84)	636.12	36,245.79				2,400.00	33,845.79	13,940.70
Cowles, Nellie N .....	.75	1,260.21	111.07			1,371.28					1,371.28	
Ellis, Charles M	—	—	—			2,377.50		2,377.50	405.00		1,473.88	
Finney, John M T	8.40	4,045.70	1,244.00			5,289.70	3,410.82				—	
Frick, William F	15.02	—	2,224.39			2,224.39	2,224.39				—	
Friedenwald, Julius F .....	.75	—	111.07			111.07		111.07			—	
Harlan, Herbert .....	.76	216.73	112.55			329.28	72.74		151.86		256.54	
McCleary, Standish .....	.75	112.38	111.07			223.45	65.22				6.37	
Osler Endowment	1.40	(626.72)	207.33			(419.39)	(419.39)				—	
Osler Testimonial	7.75	5,269.90	1,147.74			6,417.64	928.58	573.87			4,915.19	
Ruhrak, John	40.79	9,374.04	6,040.79			15,414.83	1,705.17				13,709.66	
Stokes, William Royal	3.09	1,114.80	457.61			1,572.41	236.71		550.87		784.83	
Trimble, Isaac Ridgeway	2.64	4,563.43	390.97			4,954.40			607.65		4,346.75	
Woods, Hiram	2.25	—	333.21			333.21		333.21			—	
	100.00	*61,903.45	*14,809.49	1,375.66	636.12	78,724.72	8,287.92	5,020.25	1,715.38	2,400.00	*61,301.17	13,940.70
		*To Exhibit E	*To Schedule A-1	To Exhibit D *To Schedule A-1		Total to Exhibit D					*To Exhibit E	To Summary

SUMMARY—To Exhibit A-1

CASH

Individual Accounts—above	13,940.70
Special Accounts	20,703.91
Accounts Receivable—other funds ...	3,096.56
Cordell Fund	
Cash	(27.16)
Investments	23,587.16
	<u>37,741.17</u>
	<u>23,560.00</u>
	<u>61,301.17</u>

STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
CONSOLIDATED FUND—PRINCIPAL ACCOUNT

Fund	Purpose	Balance Jan 1, 1972	Net Profit on Security Sales	Balance Dec 31, 1972
Baker	Book of Materia Medicine	1,776.41	712.92	2,489.33
Barker, Lewellyn F	Library	1,065.88	427.75	1,493.63
Bowen, Joseph S	General	25,019.27	10,057.60	35,076.87
Bressler, Frank C	General	4,910.34	1,974.23	6,884.57
Cordell, Eugene Fauntleroy ...	Relief of Widows and Orphans	9,932.00	3,992.33	13,924.33
Cowles	Books of Neurology	2,047.74	822.60	2,870.34
Ellis, Charles M	General	8,258.46	—	8,258.46
Finney, John M T	Books on Ophthalmology	22,907.87	9,213.07	32,120.94
Frick, William F	Maintenance of Frick Library and Purchase of Books and Journals	40,969.66	16,473.85	57,443.51
Friedenwald, Dr Julius	Maintenance of Friedenwald Room	2,047.75	822.60	2,870.35
Harlan, Herbert	Books on Ophthalmology	2,076.93	833.56	2,910.49
McCleary, Standish	Lectureships and Books on Pathology	2,047.75	822.60	2,870.35
Osler Endowment	Permanent Endowment for Library by Request of Dr Osler	3,814.62	1,535.51	5,350.13
Osler Testimonial	Medical Books and Maintenance of Osler Hall	21,137.61	8,500.16	29,637.77
Ruhrah, John	Library, Books, Journals, etc	111,270.71	44,738.23	156,008.94
Stokes, William Royal	Lectureship and Books on Bacteriology or Pathology	8,436.17	3,389.09	11,825.26
Trimble, John Ridgeway	Lectureship only	7,204.88	2,895.54	10,100.42
Woods, Hiram	General	6,146.49	2,467.80	8,614.29
		<u>281,070.54</u>	<u>109,679.44</u>	<u>390,749.98</u>
			<u>Schedule A-1</u>	<u>To Exhibit A-1</u>

**STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
FUNDED RESERVE**

INCOME ACCOUNT

Jan 1, 1972—Balance		6,139.88
Additions		
Dividends—Schedule A-4	956.04	
Interest—savings account	<u>324.42</u>	<u>1,280.46</u>
		7,420.34
Deduction		
Agency fees		<u>57.39</u>
Dec 31, 1972—Balance—To Exhibit A-2		<u><u>7,362.95</u></u>

PRINCIPAL ACCOUNT

Jan 1, 1972—Balance	14,169.09
Addition	
Gain on sale of securities—Schedule A-4	<u>3,654.59</u>
Dec 31, 1972—Balance—To Exhibit A-2	<u><u>17,823.68</u></u>

Exhibit J

**STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
JESSE C COGGINS—LECTURESHIP FUND**

Jan 1, 1972—Balance	5,157.81
Addition	
Interest—savings account	<u>406.81</u>
Dec 31, 1972—Balance—To Exhibit A	<u><u>5,564.62</u></u>

Exhibit I

**STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
HARVEY G BECK—LECTURESHIP FUND**

INCOME ACCOUNT

Jan 1, 1972—Balance		1,028.36
Additions		
Dividends—Schedule A-4	217.30	
Interest—savings account	<u>86.89</u>	<u>304.19</u>
		1,332.55
Deductions		
Agency fee	13.04	
Reimbursement to general fund for expenditures	<u>642.16</u>	<u>655.20</u>
Dec 31, 1972—Balance—To Exhibit A-3		<u><u>677.35</u></u>

PRINCIPAL ACCOUNT

Jan 1, 1972—Balance	2,159.81
Transactions	<u>NONE</u>
Dec 31, 1972—Balance—To Exhibit A-3	<u><u>2,159.81</u></u>

**STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
AMOS KOONTZ—MEMORIAL FUND**

PRINCIPAL ACCOUNT

Jan 1, 1972—Balance	2,407.23
Addition	
Interest—savings accounts	144.72
Dec 31, 1972—Balance—To Exhibit A-5	<u>2,551.95</u>

Exhibit L

**STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
EDUCATIONAL FUND**

Jan 1, 1972—Balance	15,938.67
Addition	
Interest on savings	101.47
	<u>16,040.14</u>
Deductions	
Medic network	392.15
Educational expense	<u>2,355.03</u>
	2,747.18
Dec 31, 1972—Balance—To Exhibit A-6	<u>13,292.96</u>

Exhibit M

**STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
MEDICAL ANNALS FUND**

Jan 1, 1972—Balance	1,496.55
Addition	
Interest on savings account	84.16
Dec 31, 1972—Balance—To Exhibit A	<u>1,580.71</u>

Exhibit O

**STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
PLANT FUND**

Jan 1, 1972—Balance	814,486.72
Addition	
Assessments	16,695.00
	<u>831,181.72</u>
Deduction	
Building repairs	4,160.62
Dec 31, 1972—Balance—To Exhibit A	<u>827,021.10</u>

STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
LEWIS HENRY STEINER FUND

INCOME ACCOUNT

Jan 1, 1972—Balance		26,560.73
Additions		
Investment Income—Schedule A-7	11,045.01	
Interest—savings account	<u>2,470.38</u>	<u>13,515.39</u>
		40,076.12
Deductions		
Agency fee	587.35	
Reimbursement to general fund for purchase of library books	<u>16,946.38</u>	<u>17,533.73</u>
Dec 31, 1972—Balance—To Exhibit A-7		<u>22,542.39</u>

PRINCIPAL ACCOUNT

Jan 1, 1972—Balance	367,298.50
Addition	
Gain on sale of securities—Schedule A-7	<u>3,542.55</u>
Dec 31, 1972—Balance—To Exhibit A-7	<u>370,841.05</u>

Exhibit P

STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
MED-CHI INSURANCE TRUST FUND

Jan 1, 1972—Balance		54,088.82
ADDITION—NET		
Income		
Administrative fees	28,192.51	
Interest on securities	9,916.63	
Retirement program	<u>3,800.00</u>	<u>41,909.14</u>
Expenses		
Insurance	833.05	
Fees—auditing	500.00	
—consulting	1,081.32	
—legal	880.90	
Postage, stationery and supplies, etc	1,513.87	
Salaries	<u>13,451.00</u>	<u>18,260.14</u>
		23,649.00
Dec 31, 1972—Balance—To Exhibit A		<u>77,737.82</u>

Exhibit Q

STATEMENT OF CAPITAL
FOR YEAR ENDED DEC 31, 1972
JESSE C COGGINS—NEW BUILDING FUND

Jan 1, 1972—Balance		143,349.86
ADDITIONS		
Gain on sale of securities—Schedule A-4	9,679.69	
Interest on savings account	1,779.91	
Investment income—Schedule A-4	<u>1,266.49</u>	<u>12,726.09</u>
		156,075.95
DEDUCTION		
Agency fees		<u>75.99</u>
Dec 31, 1972—Balance—To Exhibit A-4		<u>155,999.96</u>

WOMAN'S AUXILIARY

Mr President and Members of the House of Delegates:

I appreciate the invitation and the opportunity to address you this afternoon, and to apprise you of the activities and aims of your Auxiliary. As you know, we are the doctors' wives in this state who share with you your concern to ensure the continuing improvement of health care for all our citizens. The year has been a good one for the Auxiliary. We have experienced growth and development, building on our resources while daring to be innovative.

With the Faculty's help, we continue to raise funds for our medical schools through the AMA Education and Research Fund. This year, as I am sure you are all well aware, in addition to our more traditional fund-raising activities, we sold shares for a Mexican Holiday. The winners, Dr & Mrs Henry V Davis, Chesapeake City Md, will enjoy a free trip for two to Med-Chi's Semiannual Meeting in Mexico City in the fall. This raffle alone netted \$1,822 for the University of Maryland and Johns Hopkins medical schools.

In the political arena, we have kept abreast of federal and state legislation, pending and passed, which is affecting the practice of medicine. During the congressional campaigns last fall, our members were availed of in-depth profiles of our Maryland candidates, and many of us worked actively for the election of candidates favorable to medicine's interests. Currently, we are concerned with the ramifications of the Bennett amendment and are keeping our members up to date on congressional activity in this area.

We continue to encourage high school students interested in paramedical careers by offering scholarships, by disseminating excellent resource material through the school guidance counselors, and by arranging hospital tours for interested students. Our support and sponsorship of the Maryland Health Careers Clubs is vital to their successful operation. Further, we have, this year, awarded more than \$5,000 in scholarships and loans to deserving high school students.

Consistent with our concern for the health care needs of our citizens, many of our county auxiliaries have been meeting community needs in the areas of health education and volunteer health services. Our Auxiliary has access to excellent films and literature in the areas of drug abuse (particularly among elementary school age children), nutrition, personal safety on the streets, drunken driving, water safety, emergency resuscitation, blood donor programs, and the like. Many of our county auxiliaries have assessed existing needs in their own communities and have been busy implementing appropriate educational programs for the local populace, always with the approval of their local medical societies, of course.

This year, we restructured our state committees to parallel those of the national auxiliary in order to effect a more efficient channeling of this kind of educational material. Wherever possible, the counties have followed suit in their own committee makeup so that there is minimal delay in the implementation of necessary programs on the local (county) level which is, after all, where the real work is done. In addition, we have formed a Program Development Committee this year so that our projects will be ongoing from one year to the next.

Our charitable concern does not stop at our nation's borders. We continue to ship much-needed drugs, supplies, and medical publications overseas. In addition, we in Maryland have this year adopted a child of a physician practicing in a rural area of a foreign land. A child in this foreign land, to be properly educated, must attend school

in the city even while his physician father ministers to the sick in the hinterlands. The child's urban schooling, room and board costs \$360 a year, a cost which we have assumed, so that the child's father is free to practice where he is needed while his child receives optimum education.

At the suggestion of Dr DeLawter, the Auxiliary is in the process of setting up guidelines for a committee to assist physicians' widows. We anticipate the existence, in each county, of such a committee, to be composed of members of both the county medical society and its Auxiliary, with a like committee on the state level, to serve in an advisory capacity to the counties. Letters to this effect have already gone out to Presidents and Presidents-elect of our component medical societies and auxiliaries.

We are gratified to have had many doctors' wives join our ranks this year and we are so pleased to welcome these new members to our existing county auxiliaries. Anne Arundel's Medical Auxiliary has had, we are happy to report, a very busy and productive first year. And, in addition, we have just welcomed our newest Auxiliary, the doctors' wives of Howard County. This brings us to a total of 13 organized county medical auxiliaries in our state, with a total membership of approximately 1,000.

The inclusion of the Auxiliary on the Faculty's Committee on Program and Arrangements is greatly appreciated and has resulted in a fine working partnership of our two groups. We are grateful, too, for the Faculty's financial assistance, which has helped us immeasurably in carrying out our various programs.

The help offered to us by the Med-Chi staff (particularly Miss Wynde, Mrs Ritchie, and Mr Sargeant) is recognized and deeply appreciated by all of us who had the pleasure of working with them. It has been difficult for them, at times, to fit Auxiliary work into their busy schedules and we do appreciate their efforts. Perhaps, in time, if space should become available at the Med-Chi Building the Auxiliary will be afforded a little space we can call our own, thereby hopefully enhancing our working efficiency. But most of all, we do thank Dr DeLawter, who has encouraged and supported us throughout this year.

We are your Auxiliary and we want you to be proud of us and proud of our accomplishments. We want to share with you and want to help you when we can. The image of the mink-stoled, white-gloved, tea-partying doctor's wife is not us. We are concerned with moving with the times, with being a vital, beneficial force in our communities, and with helping you in your work of improving the quality of life for all.

Thank you.

MRS MARVIN L KOLKIN, President

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PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

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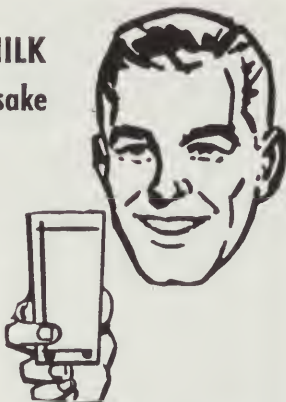
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WHERE ARE YOU?

"You know; you know what I mean; you know."

How many times in the course of a normal working day do you hear those words? Who of us really knows? I DO KNOW that in the past months we have witnessed a dramatic series of events which can shape the future of all physicians. I am not speaking of the ills of a political party which, albeit indirectly, helped to extend some very important medical legislation by the overwhelming passage of the Health Program Extension Act in both the House and the Senate, but rather of the appointment of an Advisory Council to implement the PSRO legislation, popularly known as the Bennett Amendment.

The implementation of the Bennett Amendment signals the beginning of a whole new concept which will highlight the changes which are inevitable in the growth and development of the American medical system of health care delivery. We must recognize that the single constant in history is change, not change for the sake of change alone, but change in terms of meeting new challenges.

As with any change in the status quo, a reaction has occurred. This reaction has resulted in the formation of many groups including Council of Medical Staffs, Physicians' Health Congress, American Association of Physicians and Surgeons, Committee for Human Rights, various subspecialty groups, physicians' unions, and others, each with a specific goal oriented towards its membership. While many of these groups speak of the "RIGHTS" of people or physicians, little or nothing is said of their "RESPONSIBILITIES" to serve the overall goal of American medicine.

Ten years ago a group of farsighted individuals formed an organization which, though independent, was closely linked in philosophical

content to that one single organization which (despite conflicting opinions) most universally represents American medicine. This new organization was called the American Medical Political Action Committee. It is now recognized by political leaders as the single most important VOLUNTARY, non-partisan political action group in this country. Other similar groups frequently compel membership from their component union members.

The sole primary goal of AMPAC, as implemented by your Executive Board of MMPAC, is to further the growth and development of our independent medical system by establishing lines of communication with our legislative representatives. It enables people with the experience of years of practice to act as information sources for those legislators who are expected to make laws implementing health care systems, and who are responsible for the development of a hodgepodge of proliferating titles . . . RMP, HMO, EMS, PSRO, CHP . . .

Leadership in any field, especially in medicine, requires the ability to fuse the goals of many and various individuals and groups into an acceptable consensus. This demands a unity of purpose, not a weakness of fractionalism. It is planned that your MMPAC Executive Board will broaden its base the better to achieve this end. It is also planned to enhance the role of the Woman's Auxiliary in this respect.

We must realize that important medical decisions are being made by political leaders today, not by medical leaders. Our primary goal is to play a growing role in this very important arena. The growth of MMPAC is the primary source of our involvement. Never belittle the importance of personal contact. We all know the value of the art of medicine, basically the art of communication, which frequently greatly influences the outcome for a very sick patient.

It is commonly said that politics is a dirty business. It is only so if apathetic citizens submit to dirty politics. But this is not a quid pro quo. Certainly an opinion or a vote that you can buy can surely be bought by the next highest bidder. MMPAC influences by action at the beginning of the legislative process, developing communication in the womb before elections and then continuing a broad educational process by the mutual interchange of information.

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Most Americans apparently do not consider health care much of a problem. A Gallup Poll conducted recently asked the public to name the nation's two most important problems. Sixteen problems were identified (the cost of living led the list), but health care was not among them. At about the same time, a poll commissioned by Blue Shield Massachusetts shows 56% of the public favors a federally-sponsored national health insurance program, based on need and administered by private insurance firms, over a proposal similar to the Kennedy-Griffiths-Labor plan. Only 34% favor the latter. None of those interviewed complained about the quality of medical care.

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Scientific Exhibit Winners — 1973 Annual Meeting



A large and varied number of scientific exhibits at the recent annual meeting made the job of choosing a winner a difficult one for the judges.

After considerable deliberation, they awarded the First Place Award to the "Raynaud's Disorders Revisited" exhibit. It was prepared by Francis Chucker MD, Richard C Fowler MD, and C Warren Hurley BME.

Purpose of the exhibit was to present an integrated approach to a clinical problem, utilizing Raynaud's Disorders as an example.

In the large photo, we see the three men with James D Drinkard MD, Chairman of the Subcommittee on Exhibits. L/R: Chucker, Drinkard, Fowler, Hurley.

Another scientific exhibit that attracted much attention was the one on Hospital-Ambulance Telemetry System. The two men primarily responsible for it were

Gustav C Voigt MD, Cardiologist-in-Chief, Cardiovascular Division, Baltimore City Hospitals, and President of the Central Maryland Heart Association; and Chief J Austin Deitz of the Baltimore County Fire Department Ambulance Service.

Pictured L/R: Lt Ralph G Maxwell, EMT J Sonntag, EMT Robert Harris, Dr Drinkard, LeMoyne Lindsay.

The "An Artificial Muscle" exhibit prepared by Gerhard Schmeisser MD, Chief of Orthopedics, Baltimore City Hospitals; and Woodrow Seamone, Controls Group Supervisor, Johns Hopkins University Applied Physics Laboratory and Medical Institutions, drew considerable attention and was also awarded an Honorable Mention. Pictured L/R: Schmeisser, Drinkard.





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Drug Use and Abuse

DONALD M PACHUTA MD
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PSYCHOSOCIAL ASPECTS OF DRUG ABUSE

Part 2: Treatment and the Role of the Family Physician

LEON WURMSER MD

Dr Wurmser is Associate Professor of Psychiatry, University of Maryland School of Medicine; also Clinical Director, Methadone Maintenance Treatment Program, University of Maryland Hospital, Baltimore.

How relevant is such an analysis now if we try to intervene, especially since there is often no correspondence between the amount of knowledge about causes and effective treatment?

We can quickly recognize that the two commonly propagated approaches attack the problem from the one, superficial end. The *law enforcement* approach steps in on the uppermost levels, that of the symptom—menacing proclamations of harsh sentences and measures to block availability. Yet, with the ready access of everyone to other agents of addiction or other avenues of addictive search and with the known ineffectualness of deterrence vis-a-vis such compulsive activities, we are not surprised that vindictiveness as policy, reflected in much of our legislation and political statements, renders scant help in suppressing the symptom, has no treatment, and little preventive value. *Vengefulness is grown from the same soil of archaic fears and demands as the illness it purports to attack.*

We know, too, that: "The rarer action is in virtue than in vengeance."¹ Crimes without victims lead to secondary criminality, which in turn drowns courts, police, and jails under a tide of incurable felons. They contribute to corruption of law enforcement personnel and the misery of the victims of such secondary crimes.² The laws as they exist now precisely prepare the ground for what the former Chief Justice Earl Warren so poignantly phrased: "Organized crime can never exist to any marked degree in any large community unless one or more of the law enforce-

ment agencies have been corrupted. . . The narcotics traffic of today, which is destroying the equilibrium of our society, could never be as pervasive and open as it is unless there was connivance between authorities and criminals." (*Washington Post*, Nov 14, 1970). A system of regulation and medical treatment, much like the one used in Great Britain, though far from good, and much falsely maligned, seems the lesser of two evils by far.

Secondly, we hear the sirens singing of prevention in form of *educational* efforts. This is the same as to call for sex education to prevent later rapes and sexual perversion, a naive attempt to solve a deep emotional problem with cognitive means.

In turn, our professional *revolutionaries* call for their radical remedies, approaching the problem from the other end, from that of the concurrent, unspecific causes. I submit though that to exchange revolutionary mythology and violence for the chameleonic mythology and destruction would be a poor bargain, even if it did work. That a remedy for horrible social conditions can affect a family breeding drug abuse is very true. But still, an attack on an auxiliary cause is not yet an attack on the precondition, namely, the family pathology and the individual's faulty development. And a warning to lay people, counselors and physicians alike: Do not fall into the trap of the projections which our patients commonly present: "*Everyone else is at fault; we people are victims.*" We may add the "insulin fal-

lacy" to this warning: "The body needs the drug; it's a metabolic error; there is nothing we can do about it, but to keep taking the same or other drugs."

In regard to the important practical and rational approaches on the levels between these two extremes I limit myself to some conclusions from my explanatory construct, before I turn to a more detailed description of the role of the family physician.

Withdrawal with methadone and other forms of *detoxification* approach the problem on the first level—merely alleviating the inevitable withdrawal symptoms. Unless it is coupled with very vigorous psychological assistance on other levels it is usually doomed to fail. It is preferably carried out now on an outpatient basis, but only within a specially structured program encompassing ample supportive services.

To put the patient on a *maintenance* regimen, whether with narcotics (like methadone), or tranquilizers (like diazepam), or with stimulants, reestablishes, above all, the artificial defense against overwhelming affects.³ In very many cases such a protective barrier is the only practical help which can be rendered and is absolutely invaluable. In others it may be a temporary assistance or a longterm support during a more thorough restructuring of their lives and with that a better adaptation to the underlying conflicts, while the patient is assisted in avoiding more external crises which evoke these unmanageable affects, and in living better within the limits of the defects described before. This is facilitated if the patient knows he can *depend on the program and the person of the counselor instead of having to depend on the drug*.

In this context I would like to stress the importance of certain attitudes in the treatment personnel, including physicians, which determine success or failure. They are *firmness* without rigidity—a clear setting of limits in the program; *honesty*—a refusal to play games of any kind, including to manipulate and deceive patients; and a basic *respect* for the patients and the realness of their inner and outer problems.

A methadone maintenance treatment regimen requires a broad basis of ancillary services and strict rules to protect against diversion. This, again, is not the domain of the private physician.

If we look over the many levels of causation, we cannot escape the conclusion that *combinatory forms* of treatment are far superior to one-track approaches; eg, methadone is not very helpful just as a medication, but only in combination with vocational retraining toward a more mean-

ingful job, family counseling, and sometimes psychotherapy and a residential sojourn. Probably the most important thing is lending the patient the emotional support of a big brother in the form of an advising, guiding, warning, counselor.

The either-or approach, so popular today (particularly with ignorant bureaucrats), may be justified in basic research, but not in treatment. We may draw on very similar analogies in the therapy of schizophrenia, leukemia, and tuberculosis. Again, we have to combine two, three, and more modalities for one given patient, and often simultaneously, instead of the one-track model so welcome to intellectual laziness. From a research point of view, this conclusion is distastefully messy. Practically, the funding pattern up to now precludes any combinatory treatment; personnel are hard to find even for the simple modalities that are currently propagated.

There are no sweeping solutions, answers, and magical remedies. Our inner life is very complex to understand and even more difficult to change and to cure. Perhaps it helps in all this to remind all of us what Leonardo da Vinci said: "The little truth is better than the big lie."

And, as always, theory, no matter how complex, is needed as the beacon for practice.

Role of the Family Physician

I believe that only now are we equipped to tackle the question about the role of the family physician. Obviously, he is in no position, neither legally nor practically, to start a maintenance or detoxification program with one or many patients unless he works in and with a hospital and is willing to submit to the demands, strictures, safeguards, and limitations required for an acceptable program. Good intentions and narcissism can mislead him into malpractice and folly.

However, I can see his role and specific value in four distinct areas:

1) *In prevention*. With that I do not mean the usual educational programs, but something very different which can be deduced from my earlier thoughts. The family physician is probably the best person to recognize early what Thornton Wilder so beautifully described: "Family life is like a hall endowed with the finest acoustical properties. Growing children hear not only their parents' words (and in most cases gradually ignore them), they hear the intentions, the attitudes behind the words. Above all they learn what their parents *really* admire, *really* despise . . ." and: "A man's severest judges are his children and he knows it—severest of all when they are silent."⁴ It is the physician who can be an

ambassador of reason in this mute web of demand, control, manipulation, deceit, and neglect which permeates so very, very many families. It is he who with his prestige and influence can bring about professional help when the hand-writing is on the wall, but before the children's pathology has become ossified and self-perpetuating, who can at least call in the psychiatrist and the social worker, if he himself feels unequipped to combat the brewing madness.

Another form of prevention lies in his being *very sparing with medication*. DRUGS ARE NO SOLUTION FOR LIFE'S MAJOR PROBLEMS (except for specific physical ailments). The ethos of the physician in prescribing is reflected in the respect of his clientele for the limits of the realm of drugs. If he throws pills at the neurotic troubles of his patients he does not know who will eventually grab the drugs—and his injudicious philosophy as well.

2) He can *educate*. He can and should help youngsters and their families gain adequate information. He should have sense enough to describe soberly the dangers and effects of drugs and the signal value of their use—their meaning as a signal of deeper trouble—without falling into the hysteria of mass psychology. He has to take an enlightened stand against the punitiveness and vindictiveness which our modern circuit riders of panels and mass media spread and know about the very connection between moralistic preaching and defiance. He thus can educate the families, but also the public at large, and even the politicians, to the fact that strategies of revenge have failed.

At the same time, he can help the adolescents and their families to see how important limitations, self-renunciation and self-discipline are, and that there is a broad area of reason between vindictiveness and licentiousness. Again, it is the physician who still has more prestige in our society than any other professional, who can represent a set of values now menaced from all corners of irrationality

3) He can *refer*. He should know where troubled youngsters and adults can find help. He should be able to inform them which programs work and have a decent success rate, which colleagues are capable of handling the problems he cannot handle himself, and which of the "experts" are self-styled prophets and quacks, and which are honest. In other words, he has to be informed about the resources in an area which is not his expertise.

4) He may try to acquire a modicum of *psychi-*

atric skill himself to deal competently and *without the arrogance of power and ignorance* with many of the psychiatric problems of his patients. He will listen instead of stuffing complaining mouths with pills. He will take his time instead of resorting to quick suggestions and commands. *He will advise and sympathetically guide, neither condemn, nor demand, nor laugh off.* MOST IMPORTANTLY HE WILL HAVE TO BE HONEST AND HUMBLE. With a difficult case, he may contact an experienced psychotherapist and have several *ad hoc hours of supervision*. He may become effective this way with quite a number of patients (beyond the one supervised case), and in the long run actually save a lot of time himself.

The excuse, "I would not have the time" is in this instance, as so often, penny-wise and pound foolish. *An hour of supervision at the right time may save many hours of tedious emergency work later on.*

I have started with "King Lear." I end with "Macbeth." You remember his dialogue with the doctor:

"How does your patient, Doctor?

DOCTOR: Not sick, my lord

As she is troubled with thick-coming fancies
That keep her from her rest.

MACBETH: Cure her of that.

Canst thou not minister to a mind diseased,
Pluck from the memory a rooted sorrow,
Raze out the written troubles of the brain,
And with some sweet oblivious antidote
Cleanse the stuffed bosom of that perilous stuff
Which weighs upon the heart?

DOCTOR: Therein the patient
Must minister to himself.

MACBETH:
Throw physic to the dogs, I'll none of it."⁵

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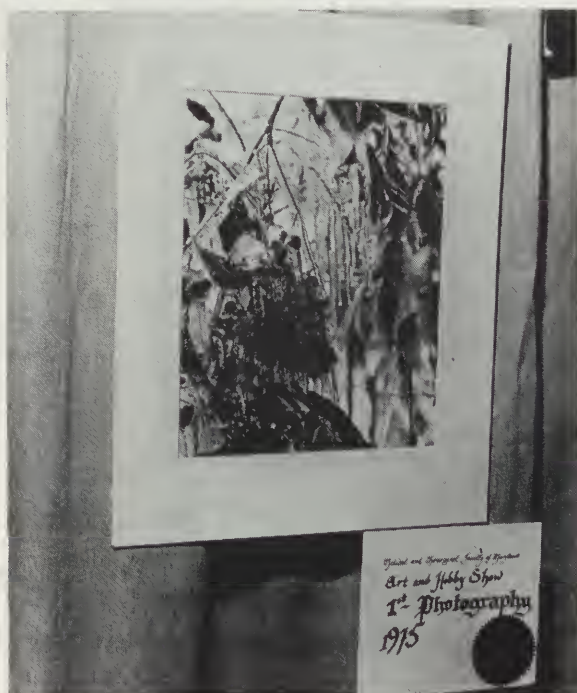
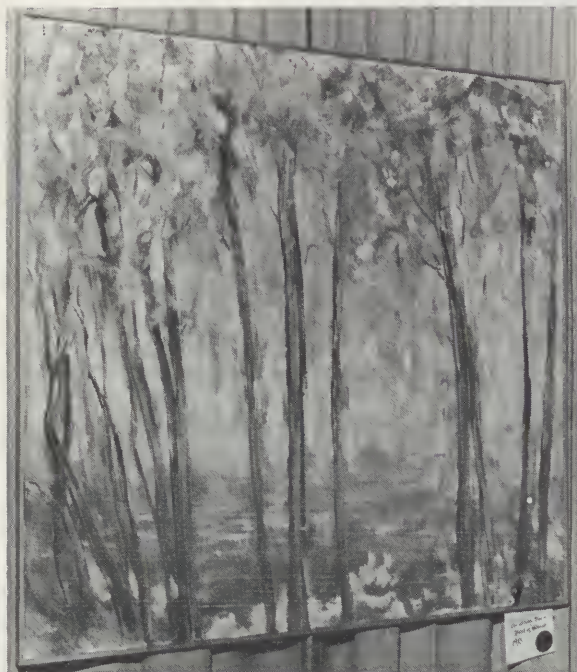
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TOP WINNERS at the Art and Hobby Show, sponsored by the Woman's Auxiliary and held in connection with the 175th Annual Meeting at the Baltimore Civic Center, April 25-27, are pictured here. These photos just cannot do justice to the sometimes vivid, sometimes subdued splashes of color in the paintings and color photography.

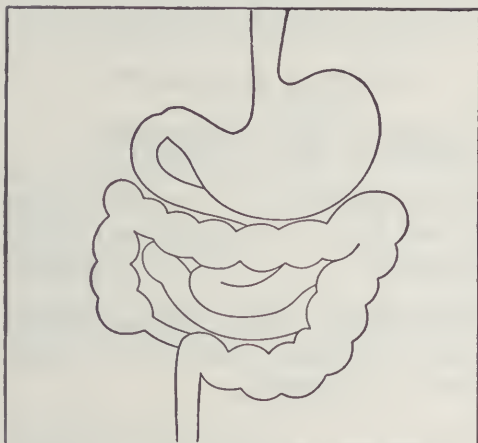
TOP—The decoys carved by Dr Emmanuel A Schimunek, Baltimore City, took 1st prize in Crafts and also copped the prize for the most popular exhibit. An entry by DeWitt E DeLawter Jr came in second.

CENTER LEFT—The "Best of Show" was this beautiful oil painting in pastel shades by Mrs D Crosby Greene of Baltimore County. Jennifer Lourdes Morales received a special honorable mention.

CENTER RIGHT—Dr Joseph Schanno of Montgomery County had two paintings that the judges awarded 1st prize in the Fine Arts category. Mrs Rafael Perez-Mera received second place.

BOTTOM—This color close-up of leaves, branches, and berries brought 1st prize in Photography to Mrs George P Blondell. Fred Schanno, son of Dr Joseph F Schanno, came in second.

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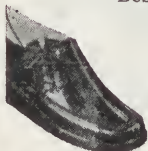
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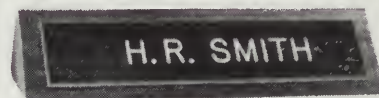
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Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug

should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are seen when they are being manifested. Side effects, when they occur, are secondary to increased rates of basal metabolism; sweating, heart palpitations without or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

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dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

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1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T₄) to Triiodothyronine (T₃) in Atheroeitic Human Subjects, J. Clin. Invest. 49:855-64, 1970.

2. Surks, M. I., Schadow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. 51:3104-13, 1972.



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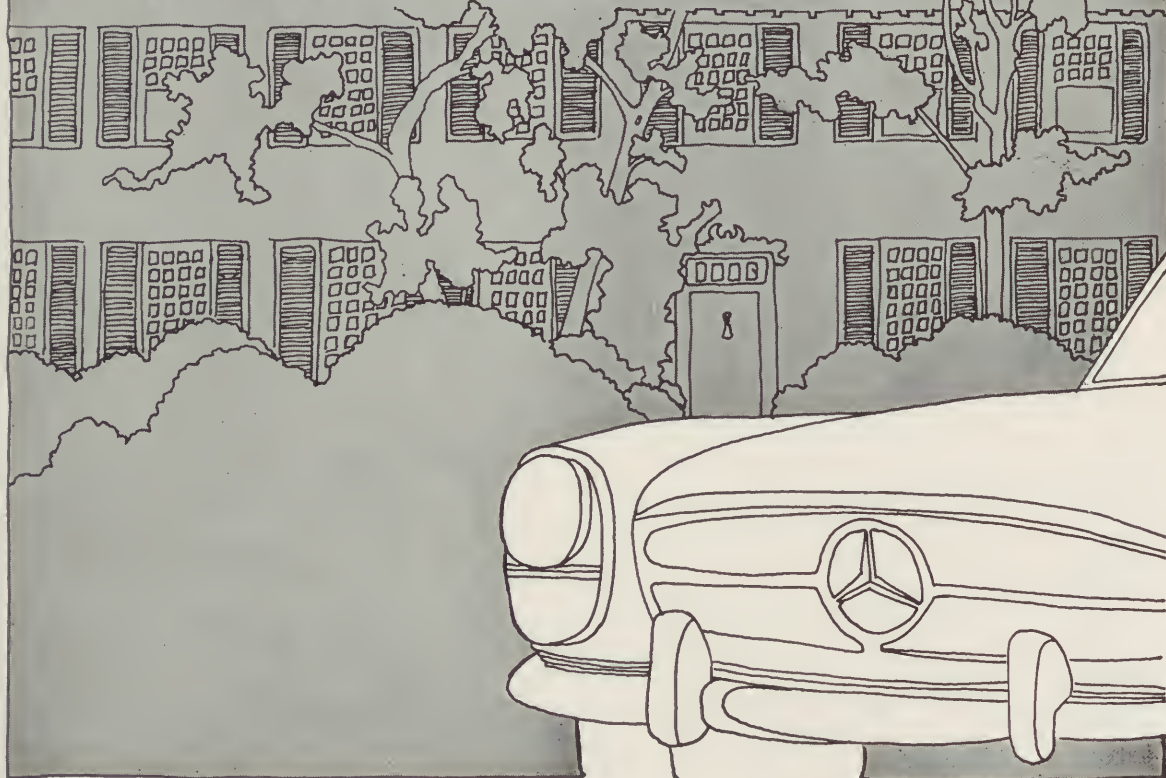
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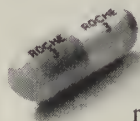
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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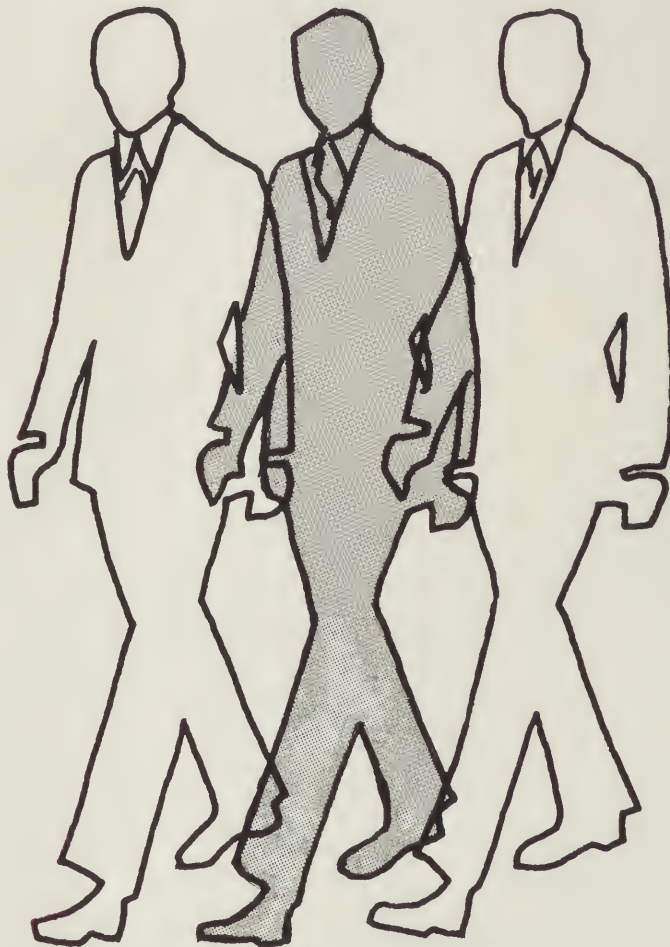
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and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug. **Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia. **Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute

and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granuloma, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-070-H(10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardley, New York 10502

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty. **Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis. **Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy. **Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy.



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your choice of sleep medication
is wisely based on more than
sleep-inducing potential

sleep with
relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

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sleep for 7 to 8 hours
without need to
repeat dosage

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

sleep with consistency

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, nonbarbiturate agent proved effective and relatively safe for relief of insomnia.

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

DALMANE[®]

(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule h.s. —usual adult dosage
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One 15-mg capsule h.s. —initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl



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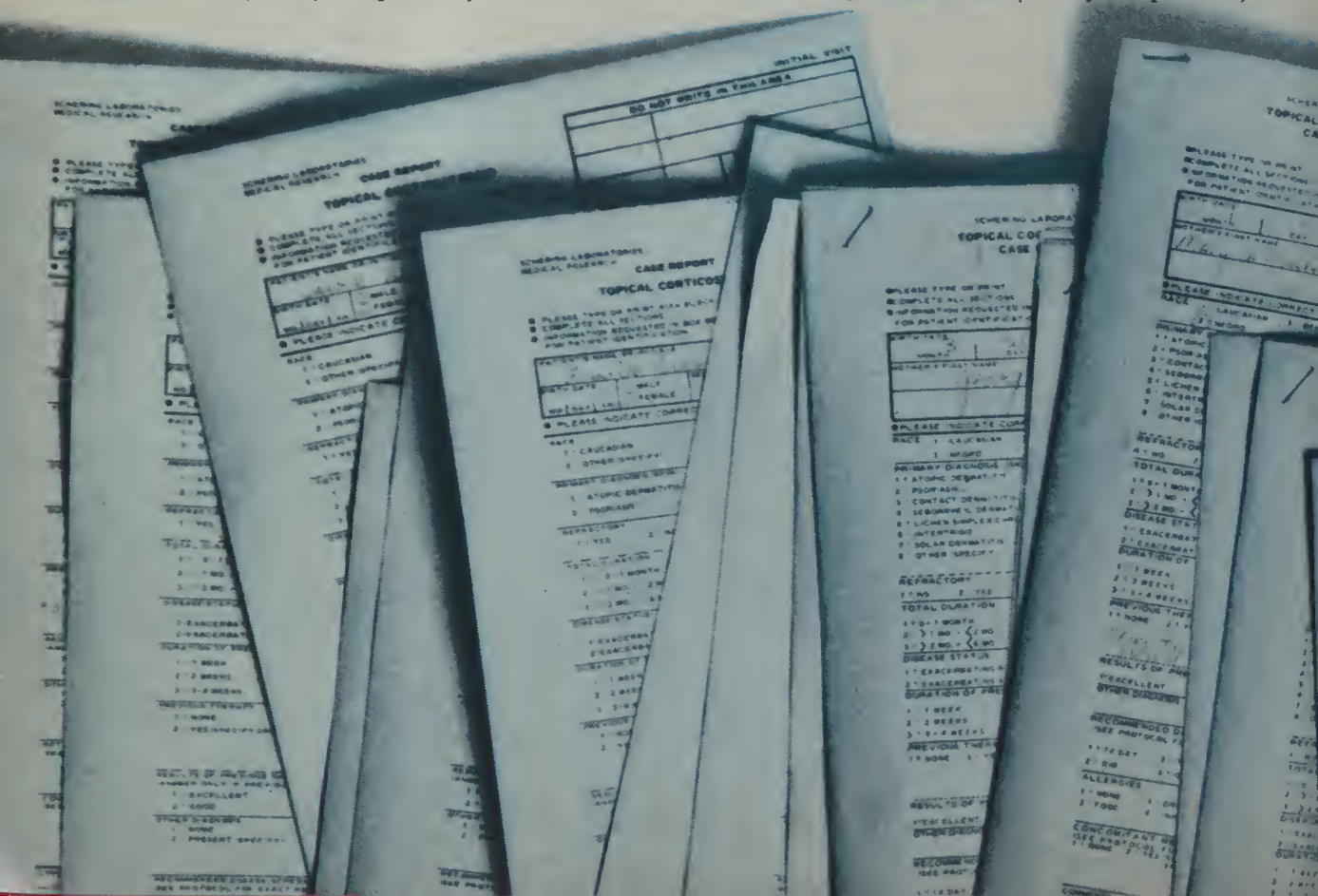
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ROCHE announces new

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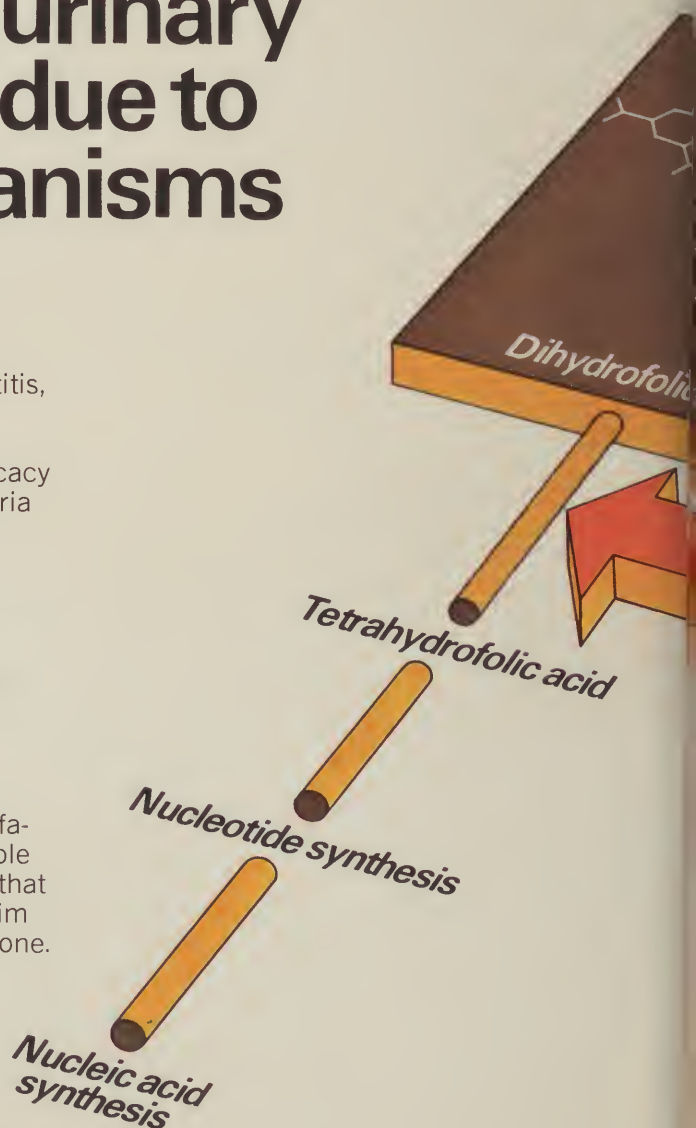
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

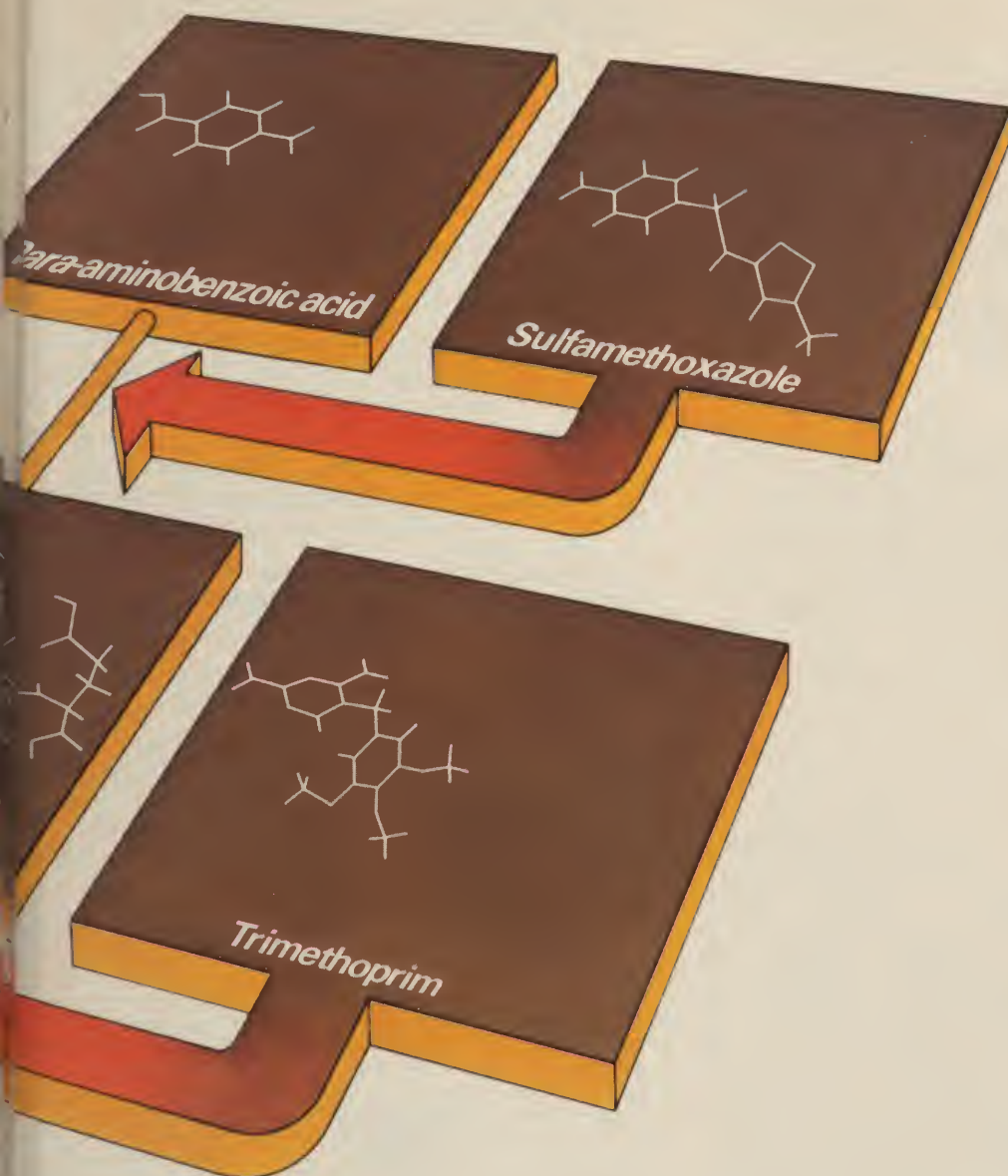
Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro** studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.



*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.



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Interrupts life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

new

BACTRIMTM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

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Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared

with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

To date, low incidence of significant side effects

Although Bactrim demonstrated impressive clinical results, it is important to note that the incidence of clinically significant adverse effects was low, mainly nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

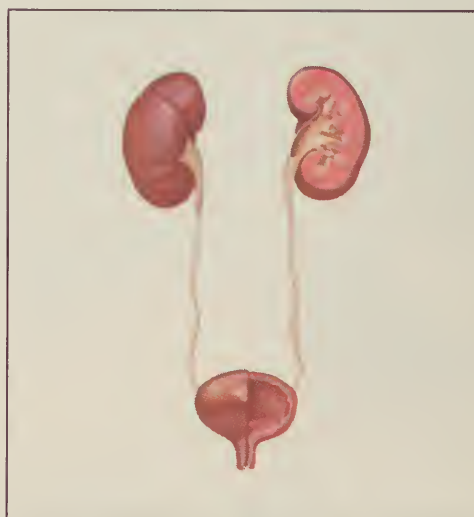
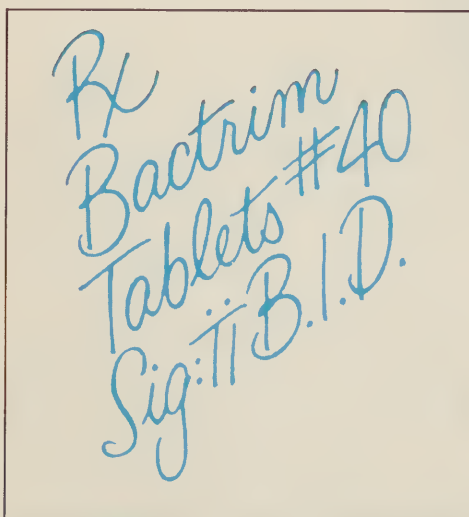
Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy or bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses with careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

† 4 patients not available for evaluation at day 10.



new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
<i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Important note: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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maryland state MEDICAL JOURNAL

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1211 Cathedral St, Baltimore Md
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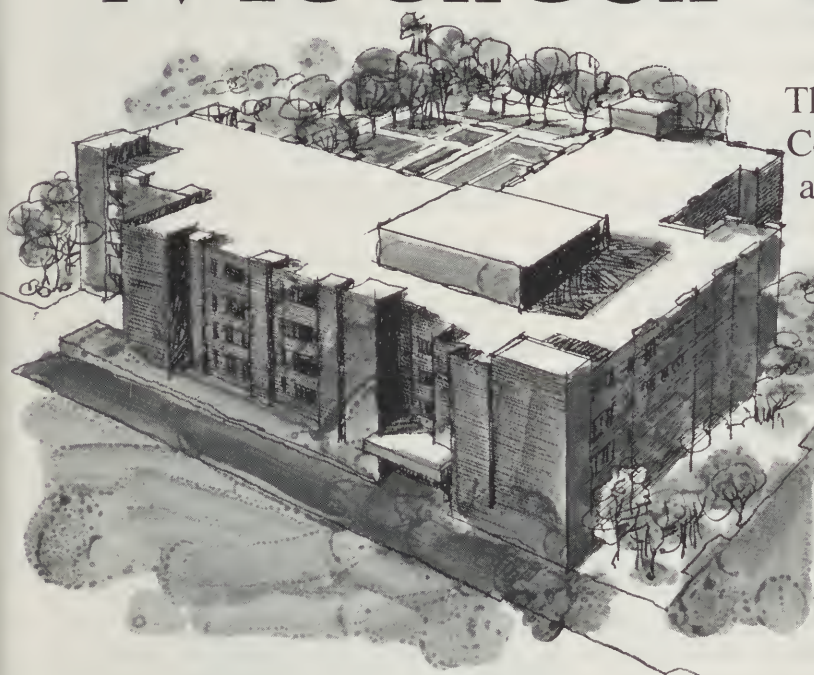
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Doctors take note...

MARYLAND AREA

- | | | |
|-----|-------|---|
| Oct | 12-13 | Medical Society of DC , anl scientific assembly, Statler Hilton Hotel, Washington. Contact: Medical Society of the Dist of Columbia, 2007 Eye St NW, Washington DC 20006 |
| Oct | 4-21 | 7th Postgrad Seminar Cruise , Georgetown Univ Sch of Med, teaching cruise aboard MS EUROPA to Eastern Mediterranean. Contact: Seminar Cruise, Allen Travel Service, 565 Fifth Ave, New York NY 10017 |
| Nov | 7 | Medical Society of DC , symposium, Can Hodgkin' Disease Be Cured? Contact: Medical Society of the Dist of Columbia, 2007 Eye St NW, Washington DC 20006 |

AMERICAN COLLEGE OF PHYSICIANS

(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104.)

- | | | |
|-----|-----------|---|
| Oct | 10-12 | Medical Aspects of Drug Addiction , Col of Physicians & Surgeons of Columbia Univ, New York NY |
| Oct | 10-12 | Physiological Approach to Mgt of Valvular & Ischemic Heart Disease , Univ of California Cen for Health Sciences, Los Angeles |
| Oct | 15-19 | Renal, Electrolyte & Acid Base Disorders , Tufts Univ Sch of Med, New England Med Cen Hosp, Boston |
| Oct | 22-24 | Individualization of Drug Therapy , Temple Univ Health Sciences Cen, Philadelphia |
| Oct | 22-26 | Office Psychiatry for Internists , Faulkner Hosp, Jamaica Plain, Mass |
| Oct | 29-Nov. 2 | Clinical Rheumatology: Diagnosis & Treatment of Arthritis & Related Diseases , Univ of Arizona Col of Med, Tucson |
| Oct | 29-Nov. 2 | Decision Making in Internal Medicine , Med Col of Georgia, Augusta |

MISCELLANEOUS MEETINGS

- | | | |
|-----|----------|---|
| Oct | 6-8 | 14th Basic Colposcopy Crs , Key Biscayne Fla. Contact: Amer Soc for Colposcopy & Colpomicroscopy, PO Box 580, Tujunga Calif 91042 |
| Oct | 11-13 | Amer Soc for Colposcopy & Colpomicroscopy , anl mtg & symposium. Contact: ASCC Symposia International, PO Box 580, Tujunga Calif 91042 |
| Oct | 15-19 | Amer Col of Surgeons , anl clinical congress, Chicago. Contact: ACS, 55 E Erie St, Chicago Ill 60611 |
| Oct | 19-20 | Workshops in gynecologic endoscopy, gynecologic endocrinology, perinatology, cervical intraepithelial neoplasia , New York NY. Contact: Jose M Ferrer, Assoc Dean, Columbia Univ Col of Physicians & Surgeons, 630 W 168th St, New York NY 10032 |
| Oct | 20-26 | Anl Otolaryngologic Assembly , Eye & Ear Infirmary, Univ of Illinois Hosp, Dept of Otolaryngology, Abraham Lincoln Sch of Med, Univ of Illinois Med Cen. Contact: OTOLARYNGOLOGY, PO Box 6998, Chicago Ill 60680 |
| Oct | 21-25 | Amer Col of Chest Physicians , anl scientific assembly, Four Seasons Sheraton Hotel, Toronto. Contact: ACS, 112 E Chestnut St, Chicago Ill 60611 |
| Oct | 24-28 | Amer Society of Therapeutic Radiologists , anl mtg, Royal Sonesta Hotel, New Orleans |
| Oct | 25-27 | Amer Col of Gastroenterology , anl crs in postgrad gastroenterology, following anl conv Oct 22-24, Biltmore Hotel, Los Angeles. Contact: ACG, 299 Broadway, New York NY 10007 |
| Oct | 29-Nov 1 | Interstate Postgrad Med Assoc , 58th anl scientific assembly, Palmer House, Chicago. Designed for family physicians & internists. Contact: Program Chmn, Interstate Postgraduate Med Assoc, PO Box 5445, Madison Wisc 53705 |

Oct	20-24	Amer Acad Pediatrics , 42nd anl mtg, Palmer House Hotel, Chicago. Contact: ACAP, 1801 Hinman Ave, Evanston Ill 60204
Oct	23	Children's Div, Amer Humane Assoc , 3rd natl symposium, Protecting Abused, Neglected & Sexually Exploited Child, Francis Marion Hotel, Charleston SC. Contact: Children's Div, American Humane Assoc, PO Box 1266, Denver Colo 80201
Oct	17-20	Amer Col of OB-GYN , Dist III mtg, Cherry Hill Inn, Cherry Hill NJ. Contact: ACOG, 1 E Wacker Dr, Chicago Ill 60601
Oct	25-27	4th Anl Radiology & Nuclear Medicine Postgrad Crs , Durham NC. Sponsor & info: Dept of Radiology, Duke Univ Med Cen, Box 3808 Durham NC 27710.
Oct	26-27	Postgrad Crs in Otolaryngology for Family Physicians , Playboy Plaza Hotel, Miami Beach. Contact Div of Continuing Educ, Univ of Miami Sch of Med, PO Box 875, Biscayne Annex, Miami Fla 33152
Oct	26-28	AMA Speakers & Leadership Programs , Marriott Motor Hotel, O'Hare Airport, Chicago.
Nov	16-18	Contact: AMA Speakers & Leadership Programs, 535 N Dearborn St, Chicago Ill 60610

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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your medical faculty at work

by John Sargeant,
Executive Director

The Council met on June 21, 1973 and took the following actions:

1. Approved the financial statements, both Operating and Dedicated Funds, through March 31, 1973.
2. Approved a recommendation for Emeritus Membership, at the request of the Prince George's County Medical Society, for Leonard Hays MD, of Barnesville Md, now retired from practice.
3. Adopted the following motion, on recommendation of the Executive Committee:
The Council ratifies the action of the Executive Committee in amending the employees' pension program in accordance with the Executive Committee minutes of April 12, 1973; and authorizes the Executive Committee to make additional amendments to the employees' pension plans as necessary for its implementation.
4. Appointed Robert B Goldstein MD, Baltimore, as Assistant Treasurer, under authority of Article IV, Section 2, of the Bylaws. Dr Goldstein has been elected as Treasurer to take office following the 1974 Annual Meeting.
5. Designated the Executive Director as Legislative Agent for the period from May 15, 1973 through the end of the General Assembly session in 1974.
6. Endorsed the AMA Medcredit proposal in the US Congress, and voted to notify Maryland's Congressional Delegation to this effect. Recommended that the House of Delegates also endorse this proposal when it meets on Sept 15, 1973.
7. Referred a proposal from the Baltimore City Medical Society regarding Peer Review to the Bylaws Committee for its consideration. This request was as follows:
When an insurance company wishes to refer a physician for peer review, a letter should be sent to the Medical and Chirurgical Faculty office stating the physician's name and asking to which component the complaint should be referred. The Medical and Chirurgical Faculty staff should ascertain the physician's locale and medical society affiliation and inform the insurance company of the name of the appropriate component society.
This action was taken, inasmuch as the proposal, if adopted, would be in violation of the Faculty Bylaws as currently written.
8. Learned that requests for underwriting information from Maryland Blue Cross and Maryland Blue Shield contains in the letter written the patient data advising that any costs incurred are the patient's responsibility. Also learned that individuals requesting such health insurance coverage may be able to obtain it without underwriting precautions such as this, inasmuch as both plans are considering open enrollment periods.
9. Adopted various amendments to the Bylaws of the Maryland Foundation for Health Care, as well as rejecting others.
10. Considered a request from the AMA Board of Trustees for nominees for various committee appointments. Prepared a list of names for submission to the Board for its consideration.
11. Rejected a recommendation that the Friday House of Delegates session be held at the Baltimore Civic Center rather than the Faculty Building, during the Annual Meeting.
12. Adopted a recommendation requesting the Mayor of Baltimore City to make welcoming remarks to the House of Delegates at its annual opening session on Wednesday morning.
13. Rereferred to the Program and Arrangements Committee for further consideration its recommendations as to the dates, location, and site of the 1974 Semiannual Meeting.
14. Appointed John S Green III MD, of Chestertown, to fill an unexpired term on the Program and Arrangements Committee, until the next Annual Meeting.

15. Heard a progress report from Russell S Fisher MD, Chairman, Ad Hoc Building Committee, in connection with negotiations with the City of Baltimore for space in the City. The Council directed Dr Fisher to discuss this matter further with the City and make a recommendation to the House of Delegates for its consideration.
16. Adopted Guidelines for the Performance of Induced Abortions and Standards for Outpatient Facilities for Abortion Service, both as recommended by the Subcommittee on Maternal Welfare. Copies of these documents may be found elsewhere in this Journal.
17. Adopted the following list of disorders "characterized by lapses of consciousness or which result in a corrected visual acuity which fails to comply with the requirements of Section 6-110.1 of the Motor Vehicle Code:

I Disorders that may lead to lapses in consciousness include:

- 1) Epilepsy
- 2) Narcolepsy
- 3) Syncope or lapses of consciousness due to Cardiovascular and Cerebrovascular causes
- 4) Chronic Alcoholism and Drug Addiction
- 5) Recurrent, severe Hypoglycemia
- 6) Any other disorder where lapses of consciousness may occur

II Any disorder which prevents a person from having a corrected minimum visual acuity of 20/40 in each eye, a field of vision at least 140°, and binocular vision

Note: It is not necessary to report a particular person's disorder previously reported to the Medical Advisory Board of the Department of Motor Vehicles.

Physicians are now required to report persons with these conditions to the Motor Vehicle Administration.

18. Approved the appointment of Margaret L Sherrard MD, Baltimore, for a three-year term on the Maryland State School Health Council Executive Board.
19. Approved a recommendation to the Division of Vocational Rehabilitation of John D Wilson MD, Hagerstown, to replace Archie R Cohen MD, Hagerstown, who is deceased.
20. Agreed to support the HAVES program (Hearing and Vision Early Screening) in its efforts to retain the referral of abnormal cases to the "primary source of health care."
21. Referred to the Bylaws Committee the question of voting membership for those committee chairmen who now serve on the Council with voice but without vote.

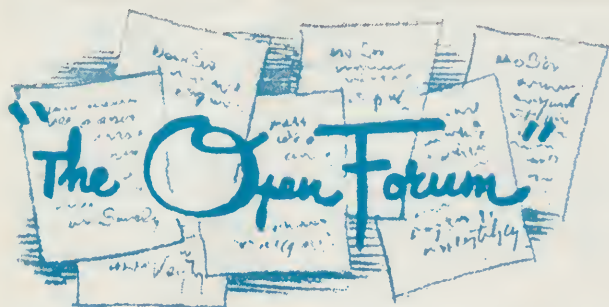
The Physician/Patient Relations Committee met on Wednesday, June 20, 1973 and took the following actions:

1. Agreed to minor modifications in the Guidelines for Promotion of Health Care Plans.
2. Heard that the Ad Hoc Committee on Advertising and Solicitation Restrictions will be meeting early in July 1973.
3. Accepted and adopted the following:

**ETHICAL GUIDELINES COVERING RELATIONSHIPS BETWEEN PSYCHIATRISTS
AND NON-PHYSICIAN MENTAL HEALTH THERAPISTS IN PRIVATE PRACTICE**

1. a. These guidelines refer to situations in which psychiatrists have formed ongoing consultative and/or supervisory relationships wherein they refer patients or relatives of patients to Non-Physician Mental Health Therapists.
- b. These guidelines do **not** apply to simple referral of a patient by a psychiatrist to an independently practicing Non-Physician Mental Health Therapist with whom the psychiatrist has no consultative or supervisory relationship.
- c. Examples of such Therapists would include: Certified Psychologists, Nurses, Social Workers, and various levels of Mental Health Counselors ranging from graduates of two-year community college programs to Therapists who now hold bachelor's or master's degrees in Mental Health Counseling.

2. Whenever a psychiatrist refers a patient to a Non-Physician Therapist with whom he has an ongoing consultative or supervisory relationship, he shall be responsible for the initial work-up, diagnosis, and prescription of a treatment plan for the patient. Such a psychiatrist is **ethically and legally** responsible for the patient's mental health care for the duration of that psychiatrist's prescribed treatment.
3. Accordingly, such a psychiatrist should assure himself that he has a proper supervisory or consultative relationship with the Non-Physician Therapist which will insure the patient's receiving optimum care. This is for the protection of both the patient's interest as well as the protection of the psychiatrist's continuing legal responsibility for the patient's treatment.
4. Such psychiatrists may either:
 - a. Enter into a **consultative relationship** with the Mental Health Therapist where the Therapist is an experienced and well-trained person such as a Certified Psychologist, MSW, etc. In this case, the responsible physician would keep himself informed of the patient's status but would **not** need to personally direct the patient's treatment or supervise the Mental Health Therapist.
 - or b. Enter into a **supervisory relationship** with the Mental Health Therapist where the Therapist is less experienced and less well-trained such as would be true when the patient is being seen by a Mental Health Counselor who is a graduate of a two-year training program. In this case, the responsible physician would personally direct and supervise the work of the Mental Health Therapist.
5. Other than within these guidelines, because of the wide range of experience and training which currently exists among Non-Physician Mental Health Therapists, it is difficult to specify what an optimum level of consultation or supervision between such a psychiatrist and a Non-Physician Therapist would be. However, it is incumbent upon the psychiatrist to satisfy himself as to the competence and level of training of the Mental Health Therapist and then provide an appropriate amount of consultation and/or supervision.
6. However, in either case, such a responsible psychiatrist with an ongoing consultative and/or supervisory relationship retains legal and ethical responsibility for the patient's welfare. Therefore, he can only ethically undertake consultative or supervisory relationships with Mental Health Therapists to the extent that he is able to keep himself fully informed of the progress of all of his patients who have been so referred.
7. It is unethical for such a psychiatrist to bill either patients, insurance companies or other third-party payers for services which they do **not** personally provide to patients.
8.
 - a. Such a psychiatrist may not bill the patient, insurance company, or other third-party payers, for supervision of the Non-Physician Mental Health Therapist after the patient has been referred. The psychiatrist may bill **only** for time he actually spends with the patient during the initial workup, etc.
 - b. This means that the Non-Physician Mental Health Therapist must bill the patient or the insurance company or other third-party payers in his **own** name for his own services at whatever rate he has agreed upon with the patient, on his own billhead. The billing may **not** be done on the psychiatrist's billhead as if he had provided the ongoing therapy.
 - c. Financial reimbursement of such psychiatrists for the consultative and/or supervisory time provided to Non-Physician Mental Health Therapists is up to individual arrangements between the two parties involved.
9. Should such a psychiatrist occasionally personally interview the patient, as part of his supervisory function, he **may** bill the patient, insurance company, or third-party payer for this on his own billhead—but only for that percentage of his hourly rate which is commensurate with the time he actually spends with the patient.
10. In situations where such psychiatrists employ one or more Non-Physician Mental Health Therapists on a salaried basis, the patient or third-party payer may be billed on the psychiatrist's billhead. However, the bill **must** note the name of the **Therapist actually providing** the service, his or her title (PhD, MSW, Mental Health Counselor, etc), the number of visits, the rate per visit, and the total charges. In such a salaried relationship, deviation from this procedure shall be unethical.



Med-Chi members are invited to write to the editor expressing their opinions or giving information on matters of mutual interest. The Editorial Board reserves the right to select or reject communications. As with other material, all correspondence will be subject to the usual editing and possible abridgement. Material should be typewritten, double spaced, of reasonable length, and not over two pages. Address: The Editor, MARYLAND STATE MEDICAL JOURNAL, 1211 Cathedral St, Baltimore, Md 21201.

Again, this year I am compiling case reports of allergic reactions to biting insects, ie, mosquitos, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc. I am also interested in reactions to the imported and Southern Fire Ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports, the type of reaction and the complications, if any, the age, sex, and race of the patient, the site of the bites, the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Send this information to the following address (Thanks in advance.):

Claude A Frazier MD
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Whether caused by flame or chemicals, a burn in the eye should be flooded with water immediately, advises the National Society for the Prevention of Blindness Inc, for approximately 15 minutes. Hold the head under a faucet or pour cool water into the eye from a glass, pot, kettle, etc. Do not use an eye cup. Burns, especially those from chemicals, should be examined by a doctor as soon as possible.

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Doctors in the News



Dr Dennis

John M Dennis MD has been appointed Acting Dean, School of Medicine, University of Maryland.

Dr Dennis has been a member of the faculty of the School of Medicine for the past 22 years and for 20 years has been head of the Department of Radiology.

A native Marylander, Dr Dennis received his BS from the University of Maryland in 1943 and his MD from the University of Maryland School of Medicine in 1945.

In making the announcement, **Dr Albin O Kuhn**, Chancellor of the University of Maryland at Baltimore, stated that Dr Dennis has shown a continued understanding of the problems and opportunities of the School of Medicine and has been an important leader in the work of the school.

Dr Dennis succeeds **Dr John H Moxley III**, now Vice Chancellor for Health Services and Dean of the School of Medicine at the University of California at San Diego.

Roland T Smoot MD, Baltimore, has been elected President, Maryland Thoracic Society, the society of physicians concerned with lung diseases.

Dr Smoot is a graduate of Howard University and the Howard University School of Medicine, Washington DC.

President-elect is **Samuel P Scalia MD**, Baltimore. Other Maryland physicians elected to the Executive Committee included **Wilmot G Ball Jr MD**, **Edward Rusche MD**, and **David G Simpson MD**, who also serves as Representative Councilor to the American Thoracic Society.

Edmund G Beacham MD, Immediate Past-President, Maryland Thoracic Society, has been elected as an honorary member of the American Lung Association of Maryland. A charter member, he was recognized for 20 years of volunteer service with the organization.



The Maryland Academy of Family Physicians has elected **J Richard Lilly MD**, Hyattsville, President, and **Howard N Weeks**, Hagerstown, President-elect.

Other physicians elected, all MDs, were: **Hans Koetter**, Secretary; **J Nelson McKay**, Treasurer; and **Harry Knipp**, **Aris T Allen**, **Harry Paul Ross**, and **Rank Thomas**, as vice presidents.

Named directors were **John Hyle**, **Philip Heuman**, **Charles Wirth**, and **Max Byrkit**.

Elected as delegates to the Academy were **Leon Berube** and **J Roy Guyther**.



Dr Fisher

At the recent annual AMA meeting in New York City, **Dr Russell S Fisher**, Chief Medical Examiner for the State of Maryland since 1949, was elected to the prestigious ten-member Council on Medical Education.

The Council has broad authority to set standards for the education of doctors and is currently grappling with a number of controversial health care issues. The Council oversees medical education in the US, setting standards for medical schools, and passing on residency training programs.

Dr Fisher, a Maryland Delegate to the AMA since 1965, was recommended for the position by Med-Chi. He is Maryland's first representative on the national hierarchy; his election to a seat on the Council came only after a spirited contest.

He is a Past President of the Faculty (1969), and is currently serving on the AMA's Committee on Transfusion and Transplantation. He also heads committees of the National Association of Medical Examiners and the College of American Pathologists.

David Bodian MD and **Helen B Taussig MD**, of the Johns Hopkins University School of Medicine, have been elected to the American Philosophical Society, the country's oldest and one of its most distinguished learned organizations.

Dr Bodian is Bayard Halsted Professor of Anatomy and Director of the Department of Anatomy. His research on polio laid much of the groundwork for development of the Salk polio vaccine.

Dr Taussig, Professor Emeritus of Pediatrics, performed the early extensive research on children's heart disease and, with Dr Alfred Blalock, developed the famous "blue baby" operation which prolonged the lives of children born with a certain heart defect.

The two Hopkins scientists were among 21 American and six foreign scholars elected to the 600-member society this year.

Maryland physicians elected to the Blue Shield of Maryland Board of Directors include **Daniel Ehrlich MD**, Towson gynecologist, and **Vincent Fiocco Jr MD**, Westminster internist.

Ernest Scher MD, has been named Chief of Obstetrics and Gynecology at Sinai Hospital of Baltimore. He succeeds **Jerome S Harris MD**, who has accepted a position in California.

Taylor Manor Hospital, Ellicott City, has appointed **Frank J Ayd Jr MD** as Director of Professional Education and Research.

Lawrence E Shulman MD, a Baltimore rheumatologist and clinical investigator, was named President-elect of the Arthritis Foundation's American Rheumatism Association Section during the recent annual meeting in Los Angeles.

Dr Shulman is Director of the Connective Tissue Division of the Department of Medicine at the Johns Hopkins University School of Medicine, a position he has held since 1955.

Dr Shulman holds PhD and MD degrees from Yale University.

Elihu E Allinson MD, Baltimore, was elected to a two-year term as Area III Representative, American Psychiatric Association, at the recent annual meeting of the Association.

Dr Allinson is Assistant Professor of Psychiatry, Johns Hopkins University School of Medicine, and Chief of Psychiatry, North Charles General Hospital, Baltimore.

The appointment of **Willa B Tommaney MD** as Deputy State Health Officer for Carroll County has been announced.

Dr Tommaney had been acting health officer since the post was relinquished last November by **J Brett Lazar MD**, who became Deputy State Health Officer for Howard County.

Dr Tommaney received her doctorate from Queen's University, Kingston Ontario, in 1965 and her MPH in Public Health from the Johns Hopkins University School of Hygiene and Public Health in 1971.



Dr Yeager

George H Yeager MD has been elected the first male President in the history of Union Memorial Hospital, Baltimore.

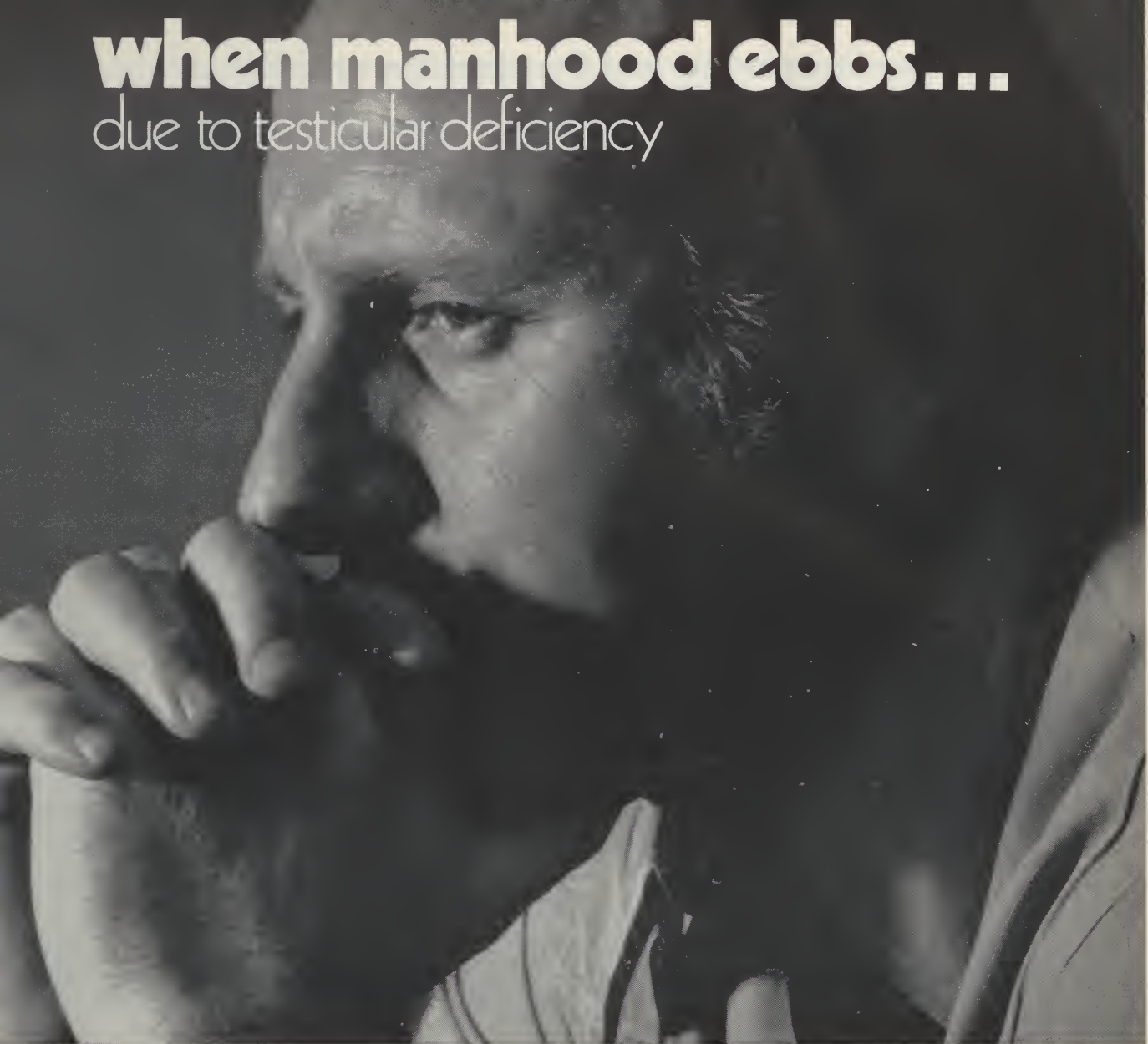
As a result of a meeting of the Board of Directors, a major corporate reorganization resulted in Dr Yeager succeeding Mrs Virginia L Nelson (who becomes Chairman of the Board) and Dr Herbert E Wilgis as Executive Director.

"Combining the offices of president and chief administrative officer provides greater continuity in the management of the affairs of the Hospital; Dr Yeager's unique background as a superb administrator and renowned physician make him eminently qualified to assume this newly defined position," Mrs. Nelson said.

Dr Yeager was Director of the University of Maryland Hospital, as well as Professor of Clinical Surgery of the University of Maryland School of Medicine until his retirement last February.

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*Cecil-Loeb. Textbook of Medicine, Vol. II, ed Beeson, P. B. and McDermott, W. eds. Philadelphia: W. B. Saunders Co., 1971, p. 1816.

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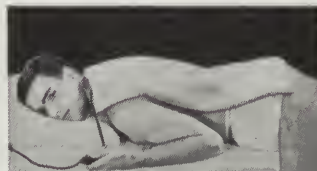
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executive director's newsletter

September 1973

ITEMS
OF
IMPORTANCE

Inadvertently, reference was made in a previous issue that the Professional Corporation law had been changed so that only four or more professionals were required in order that a name, not including the name of the professionals concerned, could be used as a PA name. The bill permitting such a change was vetoed by the Governor.

Only PAs with five or more professionals may use a Corporate name. Others must continue to use a title that includes the names of the professionals involved.

Physicians are also cautioned that APPROVAL OF CORPORATE NAMES where there are five or more professionals must be obtained through the Faculty and the Board of Medical Examiners before registration with the Department of Assessments and Taxation.

Also, of extreme importance to physicians is the requirement that patients with certain physical conditions must be reported to the Motor Vehicle Administration for an evaluation as to their driving ability. The conditions are as follows:

1. Epilepsy
2. Narcolepsy
3. Syncope or lapses of consciousness due to Cardiovascular and Cerebrovascular causes
4. Chronic Alcoholism and Drug Addiction
5. Recurrent, severe Hypoglycemia

And physicians are reminded that copies of the following statements are available on request from the Faculty office

GUIDELINES FOR PHYSICIAN'S PERFORMANCE
OF INDUCED ABORTIONS

STANDARDS FOR OUT-PATIENT FACILITIES FOR
ABORTION SERVICE

BNDD
NUMBER

It is no longer a requirement that BNDD numbers be prominently displayed in the Physician's office. New BNDD Certificates will not contain this wording.

Physicians may, therefore, remove these certificates from display and retain them in a safe place for inspection if needed.

HEW REPORT
SHOWS
PRIVATE
CARE
COSTS
LESS

A recent HEW Report has concluded that cost of medical care in private doctors' offices is materially less than it is in government operated neighborhood health centers or in prepaid capitation group practice plans.

Study found cost of each patient visit to private doctor averaged \$9.50, compared with average between \$18.07 and \$19.14 in capitation plan. But average cost in 18 neighborhood health centers operated by HEW & Office of Economic Opportunity was \$21.16, or more than double the average cost in private doctors' offices.

Study found cost of physicians' services in private practice averaged almost exactly the same as it did in health center. Nonphysician payroll for each visit averaged \$1.13 for private MDs, compared with \$5.27 for health centers. Direct costs other than payroll were tagged at 31¢ for private physicians against a whopping \$2.64 for the health centers. Overhead per visit averaged \$1.96 for private doctors, compared with \$7.08 for health centers.

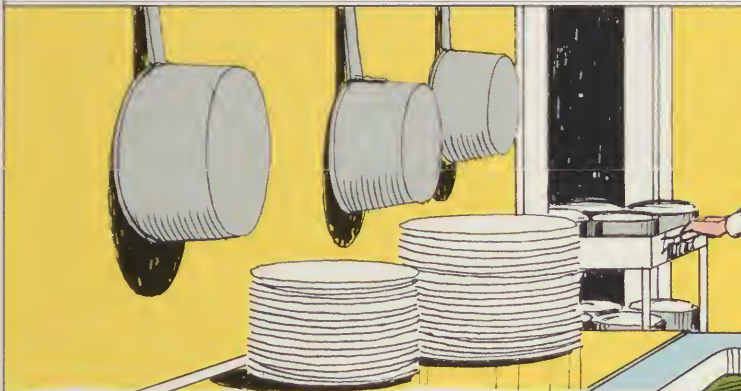
In addition, HEW report said that in computing MD costs per visit to a health center, a visit was defined as a "medical encounter" which may or may not involve a physician contact in a health center. In private practice, the report said, a visit "almost always includes such a contact."

WHO INCREASES
HEALTH CARE
COSTS?

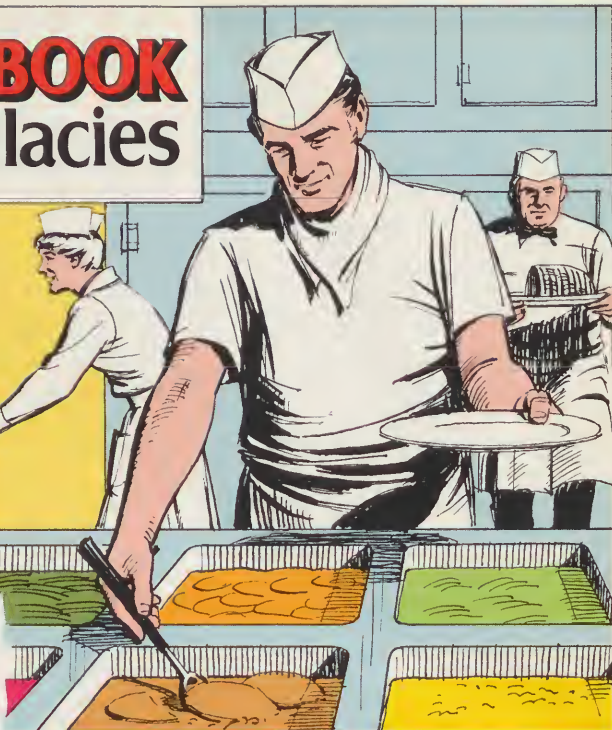
An Ohio otolaryngologist was called by a druggist to say the combination drug the doctor had prescribed for his patient had been removed from the market by the Food and Drug Administration. Having used the drug with excellent results for a number of years, the physician had to write two prescriptions to make certain his patients got the ingredients in the banned combination drug. What formerly cost the patient \$2.20 now costs him \$4.11.


Executive Director

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FRANCIS C MAYLE MD
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MRS FRANCIS C MAYLE
Editor

The AMA Convention

In his farewell address to the House of Delegates on June 24, the outgoing AMA President, C A Hoffman MD, made several references to matters involving political education and political action. Dr Hoffman opposed the Kennedy-Griffith National Health Insurance proposal, calling particular attention to the huge cost and elaborate bureaucracy that the program would entail.

He noted: "The true danger—and the true objective of the Kennedy-Griffith bill—is nationalized health care . . . the complete and total takeover of the entire health care delivery system by the government." Dr Hoffman said that this is different from socialized medicine.

"We have socialized medicine in this country . . . and we've had it for years. We have it in Medicare and Medicaid . . . in the 38% of our population covered by government programs . . . in the millions of employees covered by union programs with the premium paid by employers . . . but we must resist nationalization."

Dr Hoffman cited the specific instances in which the AMA supports governmental intervention in health care, such as manpower training, research, and construction and education grants.

Dr Hoffman called for the AMA to continue to seek a "responsible partnership with government on PSRO, and to maintain a strong political arm to prevent the improper intrusion of government into medicine. We really have very little choice in the matter, that necessity has forced upon us, like it or not."

"But the real danger is that we will like it too much. There is a subtle and seductive quality about politics that can easily trap the unwary. It is so easy to fall into the trap and to forget why one got into the game in the first place." The AMA President said it is important "to keep our basic objective clearly in mind, and that objective is to improve medical care."

"Our greatest strength as a profession is the

physician-patient relationship, and we must preserve it. That is why I am opposed to our profession turning to unions as the answer to our problems. Our sense of unity as a profession derives from serving the public . . . not from holding it as a hostage. The latter course is an inevitable result of unionism."

Dr Hoffman concluded: "This House will always be strong . . . provided the bonds of that strength are its bonds with patients, singly and collectively . . . if it can keep its windows open to fresh ideas while maintaining the quality of care as its foundation. Preserve this house of medicine, for only it can preserve your future."

Harry Schwartz, author of "The Case for American Medicine" (see pp 10-11 MSMJ June 1973), was the keynote speaker at the opening session of the Woman's Auxiliary to the AMA. His talk was based on his book which we urge all of you to read. Mr Schwartz, a member of the editorial staff of the *New York Times*, said that he is frequently asked why the media are so unfair to American medicine. Acknowledging that TV and the press are often biased, he said that real problems do exist in the field of medical delivery, including the sometimes poor distribution of doctors and facilities, the alarming cost of being seriously ill, and human problems of personal relationships.

Catastrophic insurance is a pressing need. Mr Schwartz cited three reasons why he feels medicine gets a raw deal from the press: 1) sensational or bad news sells newspapers; 2) the egalitarian influences of today's society promote envy of the financial success of physicians; and 3) socialistic influences regard health as a right and governmental activities as more virtuous than private ones.

The alarmist cries of a national health care crisis are "bunk," Mr Schwartz said. Such a crisis could hardly be ignored by both political parties as was the case in the 1972 elections.

In conclusion, Mr Schwartz urged his listeners to get to know the facts which are much better than most people believe.

Medical Miscellany

Breast Cancer Studies

The cooperation of physicians is requested in the referral of patients with breast cancer for studies being conducted by the National Cancer Institute's Medical Breast Unit in cooperation with the Surgical Breast Program at the Clinical Center, National Institutes of Health.

They are interested in following patients with primary breast carcinoma and outpatients referred for a suspicious breast lesion. Of especial interest are patients who have positive axillary nodes found at surgery.

They are also interested in referral of patients with measurable disease at time of first recurrence.

It is expected that patients not yet eligible for protocols, but who are being followed at the Cancer Institute, would not be placed on a protocol until after consultation with the referring physician.

At all times, the patient would retain the prerogative to drop out of the program. Similarly, referring physicians would have the option of withdrawing their patients from the program.

Physicians interested in further details and in having their patients considered for admission may write or call Dr D C Tormey, National Cancer Institute, Bldg 10, Rm 6B17, Bethesda Md 20014, phone (301) 496-1547.

Hidden Brook Recognized

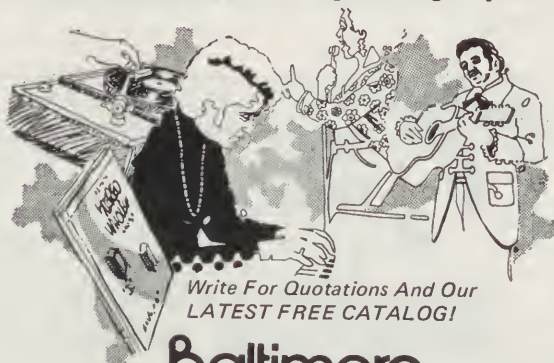
The Hidden Brook Treatment Center for Alcoholism recently reached a milestone by becoming the first in the Baltimore metropolitan region to be licensed under the newly developed Maryland State regulations governing facilities for the care and treatment of alcoholics.

In becoming a legally recognized health care facility, the technical name of the category under which Hidden Brook is now regulated and licensed is Intermediate Care Facility—Alcoholic (Type D).

Dr Leonard M Lister is Medical Director, and Joseph F Quinn is Administrative Director. Additional information may be secured by contacting them at Hidden Brook Treatment Center, Thomas Run Rd, Bel Air Md 21014, phone (301) 734-7554 or toll-free from Baltimore 879-1919.

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ACP Adds Programs

Four new learning programs for physician continuing education have been added to the American College of Physicians' Medical Skills Library. The programs (films and reinforcing booklets) portray basic medical procedures commonly performed in health-care centers, often under emergency conditions.

The new titles, which bring the Library to a total of ten programs, are Abdominal Paracentesis, Emergency Nasal Packing, Nasogastric Intubation, and Thoracentesis.

The other films are Arterial Puncture, CVP Measurement, Endotracheal Intubation, Lumbar Puncture, Tracheotomy, and Venus Cut-down.

The ACP Medical Skills Library is an audio-visual learning system combining films and single-topic books to provide step-by-step demonstrations of basic clinical techniques, indications and contraindications, instrument check lists, and physician self-appraisal material.

For additional information regarding ACP Medical Skills Library programs and their use, write to ROCOM, One Sunset Ave, Montclair NJ 07042.



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Malignant Melanoma Studies

The cooperation of physicians is requested in the referral of patients with malignant melanoma for studies being conducted jointly by the National Cancer Institute's Immunology, Surgery, and Medicine Branches at the Clinical Center, National Institutes of Health.

The purpose is to evaluate the effects of chemotherapy and immunotherapy in patients with malignant melanoma. Needed are patients with Stage III disease and Stage II disease.

Patients with Stage II disease must meet a number of rigid staging criteria. They must have had a nodular type cutaneous primary lesion with histologic level 4 or 5 invasion.

Physicians interested in having their patients considered for admission may write or call Dr R I Fisher, National Cancer Institute, National Institutes of Health, Bldg 10, Rm 4B17, Bethesda Md 20014, phone (301) 496-2455.

Kidney Research Grants

Four medical research grants have been awarded by the Kidney Foundation of Maryland to investigators in Baltimore for research during 1973-1974 into various aspects of renal disease. They are:

Norman D Anderson MD, Assistant Professor of Surgery and Medicine, the Johns Hopkins University School of Medicine, for "Studies of the Pathological and Functional Changes in Perfused Renal Allografts."

John R Burton MD, Assistant Chief of Medicine, Baltimore City Hospitals, for "A Study of Urinary Sediment Survival and Distortion under Various Conditions and a Study of Protein Selectivity Index in the Diagnosis of Kidney Allograft."

Robert M Ollodart MD, Associate Professor of Surgery, University of Maryland Hospital, for "A Study of Antihuman Lymphocyte Globulin."

Robert G Thompson MD, Assistant Professor of Pediatrics, the Johns Hopkins Hospital, for "A Study of Somatomedin Levels in Chronic Renal Disease."

The research programs of the Kidney Foundation of Maryland are largely made possible by the annual Trick-or-Treat Halloween Candy Campaign, the annual Neighborhood Door-to-Door Campaign, and other special events.

Over the past six years, the Foundation has awarded over \$130,000 in research grants to improve patient treatment and to help find the cures for diseases of the kidney, the fourth major cause of death in the country.

Seton Institute Closes

The Seton Psychiatric Institute of Baltimore Md closed recently after 133 years of continuous operation. At the time of its closing, the hospital was situated at the same site on the outskirts of Baltimore City to which it had moved in 1860.

The Daughters of Charity (Emmitsburg Md), who operated the hospital from its beginning in 1840, found it necessary to abandon plans for transferring the facility to a new location at St Agnes Hospital in Baltimore because of the lack of adequate capital funding.

The outstanding feature of the final meeting of the hospital visiting staff was the presentation of the Leo H Bartemeier Award to Dr Kermit C Edwards, a second-year psychiatric resident for his paper, "Stress as a Risk Factor in Coronary Artery Disease."

Established last year to honor Dr Bartemeier, who had served as Medical Director from 1954 to 1971, the award was given for the first (and only) time this year.

In making the presentation, Dr Hyman S Rubinstein, Staff Chairman, pointed out that Dr Edwards, by reason of the fact that he is the only one who will ever have received the Bartemeier Award, will go down in the annals of psychiatric history as having achieved a most unique distinction.

Names Changed, Goals Same

The National Tuberculosis and Respiratory Disease Association has changed its name to the American Lung Association.

In a related move, the Maryland Tuberculosis and Respiratory Disease Association became the American Lung Association of Maryland.

Officials state the goals will remain the same and that the new name is simple, direct, easier for people to recognize, to articulate, and to remember.

The ALAM Memorial Fund Committee for Medical Education and Research, chaired by Dr Douglas G Carroll, reports the following 1973-1974 awards:

1) A second-year award of \$10,000 to Dr Rustum Irani as a Fellow at the University of Maryland School of Medicine. He will work in measurement and evaluation of physiologic function and correlation with clinical findings.

2) A second-year award of \$10,000 to Dr Don Ward Bowersox as a Fellow at Johns Hopkins. He will work in the study of intensive respiratory care and diagnostic radiology.

3) A \$2,000 grant to Dr Gerald Spear to conduct research on "Ultrastructural Studies on Lethal Midline Granuloma."

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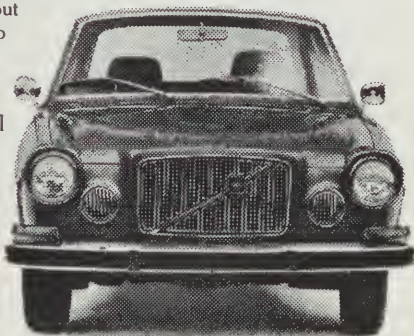
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Miss Hale

Miss Shirley Louise Hale has been named to coordinate Mercy Hospital's (Baltimore) new cooperative nursing education programs with the University of Maryland School of Nursing and the Community College of Baltimore.

The cooperative plans provide for a four-year nursing education program with the University, leading to a baccalaureate degree, and a two-year curriculum with Community College resulting in an Associate of Arts degree in nursing.

Miss Hale has served as instructor, assistant professor, and coordinator of the baccalaureate program at Maryland's School of Nursing. She has also served as an assistant instructor at the University of Pennsylvania.

A native of Hampstead Md and a doctoral candidate in human development at Maryland's College Park campus, Miss Hale has a MS in psychiatric nursing from Maryland

and a bachelor's degree in nursing from the University of Pennsylvania. She earned a diploma in nursing from the Johns Hopkins School of Nursing.

Jail Physicians

Of the 1,159 jails responding to a nationwide survey by the AMA, 65.5% said they have only first aid facilities and 16.7% said they have no facilities. In 38% of the jails physicians are available on a scheduled basis, but 31% of the jails said they have no physicians available.

The survey, conducted in cooperation with the American Bar Association, will be used to guide the AMA and state and county medical societies in developing programs to improve health services in the nation's jails.

Specialty Journals

AMA specialty journals will continue as a benefit of membership, the Board of Trustees voted. The journals were scheduled to be distributed on a subscription basis beginning in July.

The Board's action was taken in response to the views of the membership and as a result of a management reappraisal of the financial situation of the journals. Members will also receive *Prism*, the AMA's new socioeconomic journal.

Medical Care

Public dissatisfaction with medical care is not "deep or deepening," a Columbia University economics professor finds. Writing in *The Pharos*, journal of the national medical fraternity Alpha Omega Alpha, Eli Ginzberg PhD said medical care is "about as good or as bad, probably a little better, than educational services, upon which we spend about the same amount . . . I do not see any major crisis looming ahead."

Speaking of health maintenance organizations, he said: "In the face of a record that shows conspicuously slow and unsteady growth, it is difficult to understand the newfound enthusiasm for HMOs, most of which are still confined to paper."

Volunteer Physicians

Project USA, the AMA's program to provide volunteer physicians as short-term replacements for National Health Service Corps physicians in areas with critical medical shortages, has received 600 requests for information.

Twenty-one physicians have been cleared through civil service and are ready for assignment, and 25 others are in the process of being cleared. Direct inquiries to Project USA, AMA Headquarters.

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Med-Chi Salutes

SAINT JOSEPH HOSPITAL

In a group of remodeled two-story houses on N Caroline St in Baltimore City, three Catholic Sisters began their work among the sick and infirm. This was the year 1864 and Saint Joseph Hospital became recognized as a voluntary, nonprofit institution, conducted by the Sisters of Saint Francis of Philadelphia. For more than 100 years the hospital served the community in this location.

Rapid advances in medical practice and technology demanded a new type of care, new equipment, and more space to handle increased patient loads. The Sisters faced with the enforced closing of the century-old facility, rallied friends and help from the community and the government to purchase a site in the Towson area. A new, 346-bed facility was opened there on Nov 28, 1965.

The move to this 37 acres of former farmland meant much to Saint Joseph Hospital. It wasn't just a new location and building. It was growth. Eight operating rooms instead of four; a large, well-defined emergency room; a separate nursing school and residence; a large 35-bed pediatrics department; and much more.

However, the pressing requirements for more space continued. In March 1970, an adjoining convent building was opened to house the Sisters, thus freeing the seventh floor of the main building for 70 more patient beds.

The following year saw the completion and opening of the Physicians Professional Building, which provides office suites for 40 physicians. Shortly thereafter, the construction of the new Acute Care Center began. Last year this new two-story wing, as functional as modern science and architecture could make it, began serving the community by providing specialized coronary care, intensive care, short-term psychiatric care and complete EEG and EKG laboratories. The expanded Respiratory Therapy laboratory is also housed here.

Saint Joseph Hospital School of Nursing is one of the few remaining three-year diploma schools for nurses in this area, boasting a proud record of graduating more

than 1,200 young women in its 72 years of history.

Education programs are extensive, including approved programs for Interns and Residents, a school for Medical Technologists, a Physiotherapy trainee program, and participation in the preceptorship program of the University of Maryland School of Pharmacy. Structured and formalized in-service programs—medical, social, spiritual, and economic—keep pace with the needs of hospital personnel.

When Saint Joseph came to Towson, it joined hands with the Greater Baltimore Medical Center, another community hospital which had come to the area short months before, and Sheppard-Pratt, a



The Sisters' Convent



Nursing School and Residence



Saint Joseph Professional Building



Acute Care Center

long-time psychiatric facility. Now, there are monthly meetings held among these institutions and Towson State College, with a spirit of understanding and cooperation.

During the past year, this facility, now expanded to 450 beds, admitted more than 17,000 patients and treated more than 60,000 on an outpatient basis.

Throughout this metamorphosis from the old to the new, Sister Mary Pierre, OSF, has served as Hospital Administrator. This year she celebrated her fiftieth year as a Religious serving a lifetime in the health care field. Mr T Gordon Bautz is President of the Advisory Board and Harry J Connolly MD is Chief of Staff.



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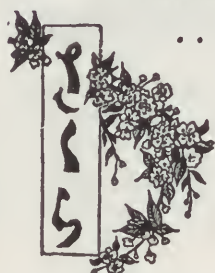
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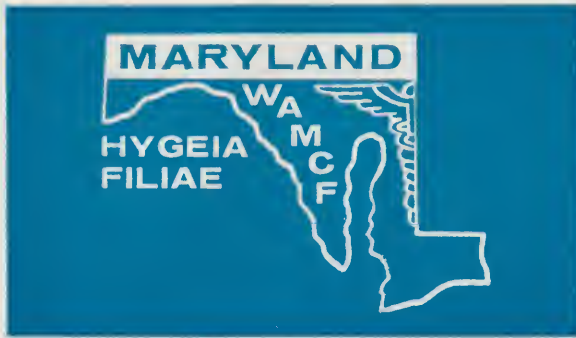
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woman's auxiliary

AMA-ERF SALUTES MARYLAND

The Woman's Auxiliary was recognized at the National Convention for their achievement this past year in donating \$30.87 per member to the AMA-Education Research Fund. We followed the District of Columbia which placed first with \$38.31.

Congratulations

Mrs Elmer (Elizabeth) Linhardt of Annapolis is the person most responsible for this grand showing. Elizabeth has been the State Chairman for AMA-ERF for several years.

Outstanding Counties

Two Maryland counties received awards for the largest contributions: Prince George's in membership category 61-100 contributed \$2,520.60; Montgomery in membership category 101-200 contributed \$6,236.62. Congratulations to these counties for a superb effort!

Faculty Benefits

This splendid showing for such a worthy program reflects favorably upon the Medical and Chirurgical Faculty of Maryland since their contributions coupled with the fund raising efforts of their wives were responsible for the results.

Maryland medical schools benefit from those donations which are earmarked for them. In this way you are helping the cause of medical education in your own state.

Many Maryland doctors who have begun practice since the early 60s have personally benefited from the donations which were earmarked for the loan fund. In these cases, the ERF funds were used to secure loans for medical students and residents to allow them to finish their training. Without this fund, their hopes would not have been realized and medicine



MARYLAND WINNERS—Pictured with the three certificates won by Maryland Woman's Auxiliary units at the recent AMA Convention in New York are, L/R: Mrs. Marvin L. Kolkin, Immediate Past President; Mrs. Leslie R. Miles Jr., President; Mrs. H. Leonard Warres, National-International Health Chairman; Mrs. Elmer G. Linhardt, State AMA-ERF Chairman; and Mrs. Francis C. Mayle, State Chairman, AMPAC.

would be in greater need of doctors than it is today. When this fund was started, there was no alternative for those wishing to enter medicine unless they had family wealth to support them.

Today's Need

At a time when medical schools are struggling for their existence amid federal cutbacks, when the number of doctors needed to adequately treat a growing population is insufficient, and the future of the private practice of medicine is being threatened, the Education Research Fund is more important than ever. Each year there

are more requests for help through the loan program than the resources can meet. Are we doing enough? What more could we do?

Easy Solution

1973-74 could be a record year for ERF in Maryland and it would not be necessary to hold large fund-raising drives and benefits. How? If each doctor purchased ERF Christmas cards for his Christmas giving and if every doctor used ERF memorials for remembering deceased friends in lieu of flowers; and, of course, the earmarking of a portion of his dues to ERF.

Maryland's fund would triple and every doctor would be doing his fair share to support medical education while gaining a tax exemption.

The Woman's Auxiliary in your county can supply you with the Christmas cards and the memorials. They are only a phone call away. Can we afford to do less?

MARYLAND AMA-ERF CONTRIBUTIONS JUNE 1, 1972 THRU MAY 31, 1973

County	Faculty	Auxiliary
Allegany	\$ 770.00	\$ 653.40
Anne Arundel	860.00	294.13
Baltimore City	5,784.00	424.99
Baltimore County	1,710.00	454.83
Carroll	435.00	122.06
Cecil	280.00	85.90

4-County

Caroline	----	
Kent	180.00	
Queen Anne	20.00	1,052.50
Talbot	332.50	
Harford	230.00	680.08
Howard	290.00	(Newly Organized)
Montgomery	4,670.00	1,601.62
Prince George's	1,910.00	710.70
Washington	280.00	542.50
Wicomico	750.00	1,186.31

Members-At-Large

Calvert	----	
Charles	140.00	
Dorchester	90.00	
Frederick	380.00	330.17
Garrett	55.00	
St Mary's	70.00	
Somerset	10.00	
Worcester	55.00	
Unlisted-At-Large	955.00	
State		1,233.85

Totals	\$20,256.50	\$9,373.04
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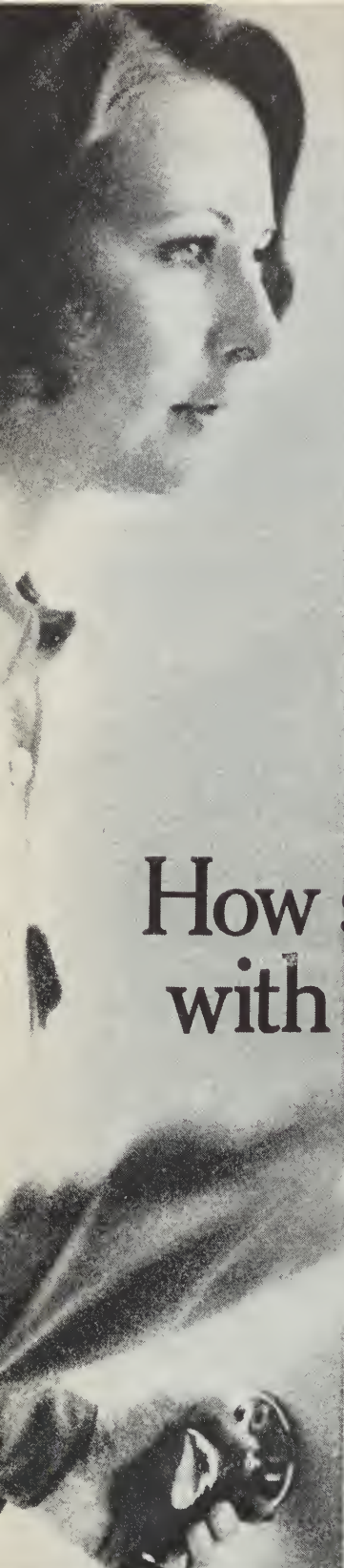
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Success in preventing recurrence of urinary tract infection usually depends on success in treating the initial infection. And that in turn is closely linked to factors of proper drug, proper dosage, and *proper length of therapy*. Much of the effectiveness of an antibacterial agent used to treat an acute nonobstructed urinary tract infection depends, in fact, upon proper length of therapy. As you know, it is potentially hazardous for a patient to discontinue her medication too soon; on the other hand, overtreatment has no advantage and may even cause adverse reactions.

Total therapy: 14 days

Some recent studies suggest that therapy in acute nonobstructed urinary tract infections should be continued for 10 to 14 days even

if patients become asymptomatic in 2 or 3 days, as they often do.¹ After inadequate treatment, of course, survival of bacteria can cause a quick recurrence of infection.

The problem of persuading a patient to complete the full course of therapy remains difficult. Perhaps agreeing on the date for a follow-up examination at the end of medication may be the most effective way of convincing a less than enthusiastic patient to continue therapy even after she becomes asymptomatic.

As a urinary antibacterial, Gantrisin (sulfisoxazole) Roche offers your patient important advantages, some of which may help increase patient cooperation.

High urinary and plasma levels

Therapeutic urinary and plasma concentrations are usually

How soon will she drop in with a recurrent cystitis...

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms.

IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infec-

tions. Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

Contraindications: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

Warnings: Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dys-

crasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis should be performed frequently.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

ached in 2 to 3 hours and can be maintained on the recommended 8 Gm/day dosage schedule at a convenient for almost all patients.

Generally good tolerance

Gantrisin (sulfisoxazole) Roche causes relatively few undesirable reactions, and serious toxic reactions are rare. Minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. Gantrisin may usually be given safely, even for prolonged periods, in the treatment of chronic or recurrent nonobstructed cystitis, pyelitis or pyelonephritis due to *E. coli* and other susceptible organisms.

(See Important Note in summary of product information.)

Complete blood counts and urinalyses, with microscopic examination, should be performed frequently.

High solubility

Gantrisin is one of the most soluble of all sulfonamides, with both free and acetylated forms highly soluble in the commonly encountered urinary pH range of 5.5 to 6.5. Urine levels have been detected in 60 minutes; therapeutic levels are usually reached in 2 to 3 hours. About 90% of a single dose is excreted in 24 to 48 hours. As with all sulfonamides, adequate fluid intake must be maintained.

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STEERING COMMITTEE ON IMMUNIZATION PRACTICES

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Medical and Chirurgical Faculty of Maryland
and the
Maryland Department of Health and Mental Hygiene

Recommended Schedule of Immunization & Tuberculin Testing

(Revised June 1973)

Approx Age of Child	Minimum Interval Between Doses	Vaccines	Skin Tests
(1) 2-3 mos	Start	DTP (1) (2) OPV ³ (1) (2) (3)	
(2) 3-4 mos	4 wks after (1)	DTP	
(3) 4-5 mos	4 wks after (2)	DTP, OPV ³	
(4) 8-10 mos			Tuberculin (7)
(5) 12-16 mos		Measles (4) (5) Rubella (5) Mumps (5) (6) DTP, OPV ³	
(6) 4-6 yrs		DTP, OPV ³	
(7) 15 yrs		Td(adult)	Tuberculin (7)

Abbreviations

DTP=Diphtheria and Tetanus toxoids and Pertussis vaccine.

OPV³=Trivalent Oral Polio vaccine.

Td=Tetanus and Diphtheria toxoids, adult type.

The Steering Committee on Immunization Practices and the Maryland Department of Health & Mental Hygiene will issue periodically a schedule of recommended immunizations for infants and children. This schedule is revised and brought up to date to conform with the latest recommendations of the Public Health Service Advisory Committee on Immunization Practices and the American Academy of Pediatrics.

If followed, it will give the child adequate protection early in life against the diseases for which vaccines are available. It should serve as a flexible guide which may be modified according to circumstances, without jeopardizing the objective of completing the schedule in as brief a space of time as is compatible with the procedures governing the administration of each type of vaccine.

IMMUNIZATION AND TUBERCULIN TESTING

Notes

- (1) When a child begins the primary series of immunizations at an older age than two months, this schedule may be somewhat condensed provided the minimum interval of one month between doses of DTP and eight weeks between the first and second doses of OPV³ are observed.
- (2) If the primary OPV³ or DTP series are interrupted for more than the scheduled interval, it is not necessary to begin the series again. Complete the three OPV³ doses or the four DTP doses regardless of the time which has elapsed since the last dose, always observing the minimum interval between doses.
- (3) When children who have received previous Salk vaccine (IPV) are given a full course of OPV³ (two doses separated by 6-8 weeks and a third dose 8-12 months later), booster doses of IPV are no longer necessary.
- (4) Infants who were given live, attenuated measles virus vaccine with measles immune globulin before 12 months of age, should be revaccinated. If it is uncertain whether measles immune globulin was administered with the live, attenuated measles virus vaccine, the individual should still be revaccinated. Individuals who have previously been given inactivated measles vaccine should also be given the live virus vaccine.
- (5) Combination attenuated, live virus vaccines of measles - rubella, and measles - mumps - rubella, are currently licensed. Either combination vaccine may be given at 12 months of age. As an alternative to using the combination vaccines, two or all three individual vaccines containing the same virus or different virus strains in combined form (further attenuated measles, mumps, rubella) may be given by separate injections on the same occasion; eg, Schwartz strain of measles vaccine and the Cenderhill strain of rubella vaccine can be safely and effectively administered at the same time. In addition, OPV³ can be administered at the same session as measles, mumps, and rubella vaccine.
- (6) Routine immunization with mumps vaccine should be given the lowest priority except for males approaching puberty who have not already had the natural infection and for institutionalized children older than one year where the threat of an outbreak exists.
- (7) When an immunization and a tuberculin test are scheduled at the same time, the tuberculin test should be given first and the immunization can follow at the time the test is read (48-72 hours). If immunization with a live virus vaccine must precede a tuberculin test, at least two months should separate them.



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CANCER IMMUNOLOGY—

A Radiotherapist's Point of View Developed as an Imaginary Interview

J ROBERT ANDREWS MD

Dr Andrews is Professional Lecturer, George Washington University, and Director of Radiotherapy, VA Hospital, Washington DC.

Information and reprint requests to Dr Andrews at 4428 Volte Place NW, Washington DC 20007.

Question: Dr Andrews, I have been hearing and reading a lot about BCG. What is BCG? Isn't it already something quite old?

Answer: Well, at least it is of this century. In 1908, at the Institute of Lille, an extension of the Pasteur Institute, Calmette and Guérin started the culture of a bovine tubercle bacillus pathogenic for cattle. As a consequence of 231 serial cultures of the organism in a beef-and-potato broth over a period of 13 years there was produced an attenuated form of the organism which retained certain of its cultural and antigenic properties but not its pathogenic characteristics.¹ Then, in 1921, in Paris, Weill-Hallé made the first human inoculation of this organism for the induction of immunity against the human tubercle bacillus.²

Q: Was it successful in preventing human tuberculosis?

A: Yes, successful enough that vaccination with the bacillus Calmette-Guérin (BCG) was made mandatory in several European countries. Vaccination with BCG for the prevention of human tuberculosis has never been widely practiced in the United States, possibly because of a lower incidence of the disease than in some European countries. It has been widely practiced, but on a voluntary basis, in Canada.

Q: But even if BCG is important for tuberculosis, what does this have to do with cancer?

A: Probably nothing. The interest in it is related to a series of concepts and discoveries and to the fact that BCG not only induces immunologic responses to itself, a specific antigen, but it also stimulates immunologic responses to other antigens, notably the human tubercle bacillus and derivatives of it, as well. In other words, it acts as a nonspecific stimulant to cell-mediated immunologic responses and is, in fact, a rather powerful stimulant. It is this immunologic stimulating property which makes BCG of potential interest in cancer management.

Q: What you are saying is that BCG may stimulate immunologic reactions against other foreign antigens including, possibly, those associated with cancer.

A: Yes, this is true. It is known, for example, that BCG stimulates resistance not only to the human tubercle bacillus but also to the Mycobacterium leprae and that it interferes with the transplantation or the course of some experimental animal tumors, and possibly of human cancer.

Q: Are there other substances which behave, in the immunologic stimulating sense, like BCG?

A: Yes, numerous others, of natural origin, have been or are being studied but none has been shown to be more effective or to behave, in terms of activity against cancer, more actively or more specifically than BCG. There is another class of antigens, not of natural origin but man-made, the haptens. These are powerful chemicals, like dinitrochlorobenzene (DNCB), which complex with tissue proteins on contact with them and become antigenic. DNCB is currently being studied in much the same way as BCG.

Q: If BCG has been so widely used over such a long period of time it seems to me, if immunity really does have anything to do with cancer, that there might be differences in the incidences of certain cancers between vaccinated and unvaccinated groups. Has this been studied?

A: Yes, it has but only in a very limited way. The concept is new and it takes time to mobilize the kind of large-scale epidemiologic investigation which would be required. But, in a limited sense, experiences in Canada have been documented.³ This epidemiological study of 342,000 unvaccinated and 408,000 vaccinated individuals showed that the incidence of leukemia in the vaccinated was less than one half of that in the unvaccinated population.

Q: You so far have been speaking of what you have termed nonspecific immunologic stimulation. What would make this specific against cancer?

A: For example, it is known, by a variety of *in vitro*, *in vivo*, and transplantation experiments, the details of which need not be developed here, that solid tumors developing spontaneously or induced chemically in experimental animals have antigens associated with them which are specific for their tumors and which are not cross-reactive with other types of tumors or similar tumors in other animals. This is not the case for known virus-induced tumors where there may be very broad antigenic cross-reactions.

Q: If this is the case, that there are, indeed, tumor specific antigens associated with some or all human cancers, and if the immunologic response is so important, why do human cancers occur at all? Why are they not destroyed at their inception? Surely, we know from experience with microbial agents that humans possess a very effective immunologic defense mechanism.

A: It is a good and pertinent question and here we must enter the realm of speculation. It seems to be true that a large tumor cell load overwhelms immunologic responsiveness and it may be that a very small tumor cell load, that is, one or a few cells at the inception of cancer, does not evoke an immunologic response. Perhaps, then, by the time that such a response is evoked the tumor cell load is already overwhelming. This would be another reason for stimulating the general, nonspecific immunologic responsiveness of known cancer patients.

Q: You previously mentioned the term, cell-mediated immunologic response. What do you mean by this; are there other kinds of responses?

A: One distinguishes broadly between those responses termed humoral, due to circulating antibodies, and those termed cell-mediated, due to antigen-activated lymphocytes and cells derived from or related to them. It is this cell-mediated immunologic response which is responsible for the killing of foreign cells, such as the rejection of foreign grafts and the elimination of cancer cells.

Q: Can the effectiveness of this cell-mediated response be tested?

A: Yes. The test is the so-called delayed hypersensitivity reaction, as exemplified, for example, by the OT or PPD tests, which identifies the presence or the absence and, within limits, the effectiveness of this response.

Q: But, again, does this have anything to do with cancer?

A: No, not specifically, but these and other similar tests, as reactions to BCG, to DNCB, to other vaccines, both microbial and viral, and to other foreign proteins, may identify an individual as either immunologically competent or incompetent and this may have a very important bearing on the behavior of cancer in that individual.

Q: Are you implying, in all of this, that the immunologically competent individual may fare better with cancer than the incompetent?

A: Yes. And this is the potential importance of the nonspecific stimulation of the immunologic response.

Q: Can you present some of the evidence for a relationship between immunologic response and the incidence or the course of cancer?

A: I shall develop some generalities and cite some references if you should wish to explore this further. I have already mentioned the lower incidence of leukemia in BCG-vaccinated populations.³ There is a higher incidence of cancer in children with congenital immunologic deficiencies⁴ and in patients subjected to prolonged suppression of the immunologic response after kidney transplantation.⁵

Patients with advanced lung and other cancers and that show strong delayed hypersensitivity (cell-mediated) reactions have better prognoses than those that do not respond and poor or non-responders that convert after nonspecific immunologic stimulation with BSG or *Corynebacterium parvum* (a diphtheroid bacterium) have better prognoses than those that do not convert.⁶

Then, too, there is the historical evidence, if we may call it such, of the modification of cancer which has been noted to accompany acute bacterial infections, notably as reported in the older literature, erysipelas. Detailed observations of this phenomenon were made in 1866 by Busch,⁷ 15 years before the discovery of the streptococcus as the causative agent. In 1868 Busch induced erysipelas in a patient with lymphosarcoma of the neck by scarification over the mass and exposing the patient in a bed notorious for the high frequency of erysipelas in patients occupying this bed. Retrogression of the tumor mass accompanied this infection.⁸

There followed a long and diverse history of the introduction of infectious organisms or their products into patients with cancer, the rise and decline of this particular era being identified with the formula known as "Coley's Mixed Toxins," the toxins of *Bacillus prodigiosus* (*Serratia marcescens*). A definitive evaluation of the effectiveness of these bacterial toxins was attempted by Nauts, Swift, and Coley in 1946;⁹ they concluded at that time that, "the study provided sufficient evidence, both clinical and experimental, to justify the conclusion that toxin therapy has clinical value."

The fact is, that although quantitative evaluation of these historical observations is impossible, one cannot escape the conclusion that bacterial infection or the administration of bacterial products somehow influences the clinical course of some cancers. These observations extend over the course of a century or more but their tentative nature should temper overly optimistic and enthusiastic predictions for the immediate future in immunologic manipulation for the relief of cancer.

Q: Let us leave, for awhile, the matter of nonspecific immunologic stimulation and go back to what you termed specific. If nonspecific stimulation is good why is not specific better?

A: It ought to be if, as has been shown to the satisfaction of most investigators, there are tumor-specific antigens associated with a given tumor or tumor type, that is, specific antigens which are foreign in the sense that cancer is foreign. This is, in fact, an old concept, the idea that a vaccine might be made of the cells of a particular patient's cancer which on inoculation or reinjection back into the patient would somehow stimulate a specific rejection reaction against the tumor.

Of course, there would always be the possibility that these cells, if live, would simply deposit themselves at various sites and grow into other tumors as, so to speak, blood-borne metastases. For this reason various methods have been employed to render the cells nonviable but retentive of their immunological properties. Such treatments have included heat, chemicals such as formalin, and X-irradiation. The fact is that, however attractive the theory, the method has not so far worked conclusively in practice. It is, however, an area of very active investigation.

Q: Earlier, you mentioned that the cell-mediated immunologic response responsible for the killing of foreign cells was the reaction of antigen-activated lymphocytes and cells derived from or related to them against the foreign cells. If there are specific antigens associated with similar types of tumors occurring in different individuals, it would seem to be a simple matter to withdraw and to separate lymphocytes from a patient apparently cured of the particular cancer and to inject these into a patient with the same kind of cancer under treatment.

A: Yes, this possibility surely does exist and it is under very active investigation. It is given the name of "adoptive" immunization. We have spoken so far of nonspecific immunologic stimulation and specific immunologic stimulation. We now add a third method, not stimulating but passive: the adoptive transfer of immunity. It is rather like administering antitoxin after exposure to certain infectious agents. The administration or the presence of the immune lymphocyte as an intact entity is not essential to the transfer of the specific cell-mediated immunity for the transfer may be effected by disrupted cells. This was demonstrated by Lawrence¹⁰ in 1955 who gave the name, "transfer factor," to whatever it was which was released from the disrupted cells and effected the transfer of the im-

munologic properties. It has since been determined that this transfer factor is a substance of low molecular weight which will transfer to the recipient the state of specific cell hypersensitivity to the antigen which induced this state in the donor.¹¹

Q: You have already talked about what you have termed nonspecific immunologic stimulation, specific immunologic stimulation, and adoptive transfer of immunity. Are there any other methods which you can describe?

A: The categories cited are in general used in the biomedical literature; I do not identify other major methods or variations which cannot or do not fit into one of these three categories.

Q: Well, then, we have come to the end of our discussion about the historical and scientific background of and the possibilities for the immunologic prevention or treatment of cancer. As a radiotherapist you must have some acquaintance with cancer; what are you, yourself, doing or what will you do with immunologic therapy in your patients?

A: This depends, in part, on whether I am playing the role of physician or of scientist-investigator.

Q: Do you make a distinction between these roles and, if so, what is that distinction?

A: There surely is a distinction and this distinction is both essential and acceptable and the objectives of the two roles should not be confused with one another.

Q: Will you define those objectives and then indicate how this relates to the problem at hand: cancer immunologic therapy?

A: The objective of the physician is the immediate and projected welfare of his patient; that of the scientist-investigator is the answer to the question which the investigation is designed to study, without, however, the denial of relief to the patient under study. The investigation of new treatments does, however, carry a higher level of risk of iatrogenic injury for if, on an *a priori* basis, it could be shown that the new treatment is both more effective and less harmful, there would be no need to do the investigation. This level of risk distinction is the principal conceptual difference between clinical practice and clinical investigation. The other important difference is that the latter requires the mobilization of resources which may be quite different from those required for clinical practice. The requirements for clinical practice will be either more simple or more standardized.

Q: Without discussing the potentialities for clinical investigation, to say nothing of the po-

tentialities for investigation in the experimental laboratory in this important field of cancer, what, then, would you, do in clinical practice?

A: I should first try to distinguish those patients with cancers for which effective treatment is presently available and for whom the prognosis is good from those patients with cancers for which effective treatment either is unavailable or is uncertain and for whom, therefore, the prognosis is poor. In this latter category I would include cancers of the lung; the breast, with extensive axillary or presumptive internal mammary lymph node metastases; the colon and rectum; the pancreas; the melanomata; and the advanced cancers of the uterus, ovary, and head and neck. I would, in such cases and using simple means, make an evaluation of the delayed hypersensitivity reaction by documenting the cutaneous responses to PPD, a human gram-positive mycobacterial antigen; to mumps, a human viral antigen; to streptokinase, a human gram-negative bacterial antigen; and to *Candida albicans*, a human fungal antigen.

There is no practical way in clinical practice to test the reactivity of the patient to the antigens of his own cancer. At the same time I would make an initial inoculation of BCG so as to induce sensitivity for subsequent nonspecific stimulation of the general immune response by repeated inoculations of BCG. The technical or clinical procedure for doing this need not be described here for it is documented elsewhere.¹² In the initially immunologically unresponsive patient, I would repeat the cutaneous hypersensitivity tests after some months of BCG therapy.

Q: You are assuming, then, in trying to stimulate immunologic responsiveness, that if a little bit of such responsiveness is good, more is better. Is there no danger to this?

A: For the simple procedures described, the probability of serious injury is very small, if, indeed, such a probability exists at all. There may be local discomfort and a febrile reaction to any foreign antigen and in the case of BCG there will be, in a very small proportion of patients treated, a small ulcer at the site of inoculation which may, in exceptional instances, persist for some months. Such would be, of course, an indication for interrupting BCG therapy.

Q: What you have outlined doesn't seem very complicated or difficult. Would you do nothing else along immunologic lines?

A: Yes, I would try to be aware of scientific and clinical progress in cancer immunology and I would introduce, as feasible, into clinical practice those methods which seemed appropriate

either in respect of general principles, such as BCG, or in respect of individual patient possibilities and needs, such as tumor-specific antigens as vaccines or the adoptive transfer of immunity. In the case, for example, of the patient with melanoma in whom known effective methods of treatment were failing I would use not only BCG alone but, if possible, in combination with the patient's own irradiated tumor cells,¹³ or I should try to find a patient apparently cured of melanoma as a source of immunologically competent lymphocytes.¹⁴ I think, also, that it would be worthwhile to try to establish "reserves" of continuously cultured lymphocytes from patients apparently cured of the very dangerous cancers.

Q: But such lymphocytes are also "foreign." Is there no danger of them reacting against the patient rather than against his cancer?

A: Yes, this hazard exists; it is given the general name of "graft-versus-host" (GVH) reaction and it may be seen in bone marrow, kidney, and other normal organ transplantations. Preferably, it is conceivable that the active "transfer factor" could be extracted from such lymphocytes in which case the patient would not be at risk of the GVH reaction.

Q: What will the Bureau of Biologics of the Food and Drug Administration say to all of this?

A: I have questioned the Bureau about this in respect of clinical practice today. The position of the Bureau is that BCG has been around for a long time; its characteristics are well known; and certain preparations have long been approved for interstate distribution for vaccination against tuberculosis. BCG is therefore, readily available for that specific use.

Where other uses are made the decision to do so must rest with the conscience of the physician or with the institution to which that physician may be responsible. The Bureau of Biologics recognizes, however, the established nature of BCG and the current interest surrounding it in cancer investigation and the Bureau may, upon request, waive certain requirements in order to expedite the study of BCG.

Q: Thank you. What you have to say is all very interesting and I think that you have indicated some directions which many of us could and ought to take in developing the clinical application of cancer immunology.

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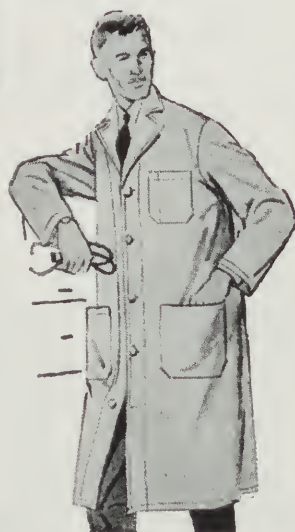
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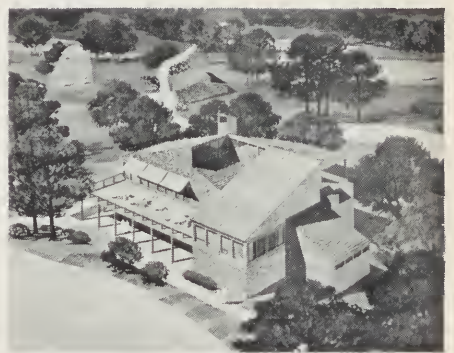
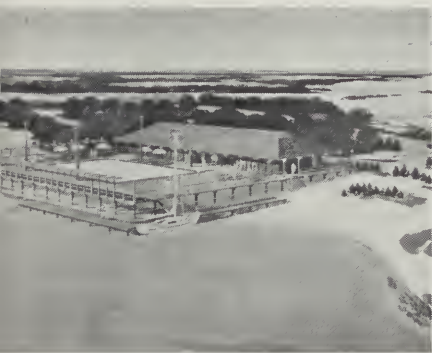
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Are Class 1 and Class 2 Pap Smears Objectively Interpreted?

LEON W. BERUBE MD

Dr Berube, a member of the Maryland State Medical Journal Board, is a General Practitioner in St Mary's County Md.

Abstract, Summary

The author observed that envelopes returned from the clinical laboratory with several Pap smear reports appeared to contain an inordinate number of Class 1 or Class 2 reports. The question arose: Are these reports objectively determined?

An attempt was made to interest the clinical laboratory to provide data to help determine the degree of objectivity in the raw or unreviewed results of two laboratory technicians.

This attempt was unsuccessful, but the results of 1,000 consecutive Pap smears were obtained and the technicians reviewing 106 of the author's 110 Pap smears were identified.

From this available data, mathematical techniques were developed to determine independence and randomness of the series and to compare the composition of the actual sequences to that of one determined with total objectivity.

The author tentatively concludes that the clinical laboratory's results very likely represent a high degree of objectivity by the professional staff in interpreting the individual Pap smear.

Report

This paper stems from the author's observation that oftentimes when an envelope containing the results of five or six Pap smears was re-

ceived from the clinical laboratory the results would appear to have an inordinate number of Class 1 or Class 2 reports. Questions arose: Are these reports accurate? Do they reflect an objective determination or are they unduly influenced subjectively to make the distinction between Class 1 and Class 2 results meaningless?

Following the clinical pathologist's careful review of the smears to establish accuracy, the laboratory technician could, without his knowledge, review his smears in the same and rearranged order two or three times. Correlating the technician's results with those of the pathologist's and with his own reviews would be a function of his accuracy and his subjectivity. This and other methods one could devise to test for objectivity involve doubling or tripling the work load; in that sense, they are inefficient, expensive, and wasteful of time and talent.

An alternate method would be to examine a technician's reports and see if the percentages and distribution of Class 1 and 2 smears fall into a pattern that is consistent with that of an objectively determined series. If it is, then one could assume that the result is objectively determined; or, to be more precise, one could assume that it is not subjectively determined.

Similarly, the individual practitioner would like to

know if his cases, representing a sample of the series, are objectively reported. Does an analysis of the results of his small series suggest that it is consistent with that of the larger series from which it came?

Although it was not possible for the author to interest and involve the commercial laboratory in the techniques mentioned to assess technician objectivity or to identify the technician who interpreted each of the 1,000 slides, it was possible to receive from them the results of 1,000 consecutive Pap smear reports. If one assumes that the percentages of Class 1 and Class 2 reports in these 1,000 cases are indeed accurate, then one can try to verify the implicit claim of objectivity through mathematics.

In order for Pap smear reports to be considered objectively reported they must be independent; ie, in nonmathematical terms they must have nothing to do with one another. A coin tossed into the air will land either heads or tails. The result of each toss is independent of all past or future tosses.

To express independence mathematically is somewhat more complex. Two events, A and B, are independent of each other if the probability of Event A times the probability of Event B equals the probability of Event A and B, or $P(A) \times P(B) = P(A \cap B)$.

Independence is not always apparent; perhaps this example might help. Suppose ten men and ten women were asked to choose their preferred form of contraception

Table 1				
	Tubal Ligation	Vasectomy	BC Pills	Rhythm
Men	.3	.4	.2	.1
Women	.1	.5	.3	.1

Table 2								
Pap #	1-1	1-2	2-2	2-1	P(A)	P(B)	P(A)xP(B)	P(A∩B)
1-100	32	24.5	19	24.5	.56	.51	.29	.32
101-200	19	24	35	19	.43	.54	.23	.19
201-300	33	22	23	22	.55	.56	.28	.33
301-400	38.5	21.5	18.5	31.5	.59	.56	.33	.38
401-500	17.5	22.5	38.5	22.5	.40	.56	.22	.18
501-600	26.5	22	28.5	23	.48	.55	.26	.26
601-700	29	22	28	22	.51	.57	.29	.29
701-800	33	22	24	22	.55	.57	.31	.33
801-900	31	19	30	20	.50	.61	.31	.31
901-1000	32	26.5	16	26.5	.58	.48	.28	.32
Average	29.1	22.6	26.0	23.3	.51	.55	.28	.29

and the results were: men—3 tubal ligation, 4 vasectomy, 2 birth control pills, 1 rhythm; women—1 tubal ligation, 5 vasectomy, 3 birth control pills, 1 rhythm.

This can be arranged in tabular form (Table 1).

The probability of selecting individuals preferring birth control pills is 0.2 for men and 0.3 for women. To exercise independence in choice 0.2×0.3 or 0.06 is the probability that a man and a woman selected at random would both desire to use pills.

If these 20 people were ten couples and each person in the couple was asked which form of contraception he or she individually preferred, the results might be something like this: Couple 1) (man-woman) tubal ligation-rhythm; 2) pill-pill; 3) vasectomy-pill; 4) pill-pill; 5) vasectomy-vasectomy; 6) rhythm-tubal ligation; 7) vasectomy-rhythm; 8) tubal ligation-vasectomy; 9) tubal ligation-vasectomy; 10) pill-pill.

From this experimental determination one sees that the probability of both a man and

a woman selecting pills is not 0.06 but rather 0.3, five times the probability when they were asked prior to becoming couples. The second selection of contraceptive choice is clearly not independently made. The effect of the influence of one person on the other is significant and their individual independence was lost.

Returning to the Pap smears, independence would mean that the interpretation of one Pap smear would not affect the interpretation of the following Pap smear. Disregarding Class 3 smears, the possible combinations of two consecutive Pap smears are 1-1, 1-2, 2-1, 2-2. Let event A be defined as Class 1 being the first report of the pair. Then Event A will be sequences 1-1 and 1-2. Let event B be defined as two successive similar Pap smears. Then Event B will be sequences 1-1 and 2-2. Event $A \cap B$ is therefore only sequence 1-1. For independence to exist $P(A \cap B) = P(A) \times P(B)$ or in this case $P(1-1) = [P(1-1) + P(1-2)] \times [P(1-1) + P(2-2)]$.

Ten groups of 100 consecu-

tive reports were investigated for independence. The results are tabulated in Table 2.

In the series of 1,000 Pap smears there were 509 Class 1, 479 Class 2, and 12 Class 3 reports. To vastly simplify the mathematics, Classes 1 and 2 are both considered to be 50% and have a probability of 0.5. When a Class 3 report was encountered in investigating independence it was replaced first with a 1 then with a 2 and a value of $\frac{1}{2}$ was given to each sequence obtained with these substitutions.

$P(A \cap B)$ agrees very closely with $P(A) \times P(B)$ in each of the ten 100 case series. A ratio, $P(A \cap B) / P(A) \times P(B) = 1.04$, for the entire thousand cases is indeed in remarkable agreement with mathematical theory, and supports the assumption that the reports are independent.

The difference between the calculated values of $P(A \cap B)$ and $P(A) \times P(B)$ and the theoretical value of 0.25 suggests that some or all of the three conditions assumed in the theoretical determination are not totally valid in actual experiment. These assumptions are 1) the probabilities of Class 1 and 2 reports are 0.5 and 0.5, 2) the series is sufficiently long, and 3) the readings are totally objective.

Consider the extremes possible. If all the reports were in the order 1212121 . . . $P(A \cap B)$ would be 0. If 500 consecutive ones were followed by 500 consecutive twos $P(A \cap B)$ would be 0.50. These are the limits of probability and the series obviously would become suspect for independence if these sequences were so reported.

The values actually deter-

mined for $P(A \cap B)$ and $P(A) \times P(B)$ in the 1,000 slides are 0.29 and 0.28 respectively. This degree of agreement between actual findings and those anticipated by theory is reassuring and suggests that the three assumptions made are generally valid.

Another property of the series, randomness, was also investigated. To be random means that a selected sample can be considered as a valid representation of the large series from which it was selected. It enables one to draw conclusions about a large series of similar events without the need to examine all the events. Political polls are based on random samples; so are TV ratings. Assembly line control is also based on the results of random samples showing the number of approved and rejected items.

The Pap smear results were divided into ten groups of 100 to see if each of these smaller series would respond like random samples and could so be considered. Mathematical formulas have been derived to test a series for randomness. A series that is considered random has for a given number of 1 and 2 reports a number of runs; ie, clusters of similar reports, which would be expected to occur by chance more often

than once in 20 times. All ten groups satisfied the conditions for randomness. Therefore, evaluating series of 100 reports is sufficient to gain insight into the results of all the Pap smears being processed.

Another question involving subjectivity warranted mathematical investigation. Is there a tendency to shorten or lengthen the runs of similar reports? For example, after five consecutive ones is there a tendency to call the next smear a 1 to keep the run going or to call it a 2 to keep from having too many alike? Since the identification of the particular technician for each of the 1,000 Pap smears is not known one can not tell from the available data whether or not this tendency does exist for a particular technician. Nevertheless, the method is valid and serves to illustrate the mathematics involved.

To investigate this tendency, one must consider the concept of runs or intermittences. An intermittence of a Class 1 report can be defined as a sequence in which a Class 1 report is preceded and followed by a Class 2 report. An intermittence of a Class 2 report can be defined in a similar manner. This means an intermittence or run of one can occur with either a 212 or a 121 sequence. A run

of two with either a 2112 or a 1221 sequence or a run of three with either a 21112 or a 12221 sequence, etc. Since the analysis of the 1,000 consecutive Pap shows that both $P(1)$ and $P(2)$ are both very close to 0.5, the mathematics is greatly simplified. For example, the probability of an intermittence or run of three ones $P(3-1s) = P(2) \times P(1) \times P(1) \times P(1) \times P(2)$ or $\frac{1}{2} \times \frac{1}{2} \times \frac{1}{2} \times \frac{1}{2} \times \frac{1}{2} = 1/32$. It is obvious that this can be generalized to any given length of run consisting of z Pap reports $P(z) = \frac{1}{2} (2+2)$. If the probability of a run of three ones is $1/32$ and there are 1,000 terms then there should be $1,000/32 = 31$ runs of 3 ones. In like manner runs for Class 1 and 2 reports have been calculated from theory and determined by analyzing the sequence of 1,000 consecutive Pap reports. The results are tabulated in Table 3.

In general, the correlation between the theoretical results and the actual results is high and reinforces one's faith that objective results are obtained from the laboratory.

In order to investigate the author's observation, ten batches of 11 Pap smears each were mailed to the clinical laboratory.

The first report in each mailing was arbitrarily con-

Table 3

Runs	13 to												
	1	2	3	4	5	6	7	8	9	10	11	12	17
1 Actual	106	57.5	26	13	10	4	2.5	2	1	1	1	1.5	0.5
1 Theory	125	62.5	31.5	16	8	4	2	1	0.5	0.25	0.12	0.06	0.002
1 Ratio A/T	.85	.92	.83	.83	1.25	1	1.25	2	2	4	8	24	256
2 Actual	102.5	65	19.5	15	9	7.5	2.5	1	1	0	0.5	0	0
2 Theory	125	62.5	31.2	16	8	4	2	1	0.5	0.25	0.12	0.06	0.002
2 Ratio A/T	.82	1.04	.62	.95	1.12	1.9	1.25	1	2	0	4	0	0
1 & 2 Actual	209	122.5	45.5	28	19	11.5	5	3	2	1	1.5	1.5	0.5
1 & 2 Theory	250	125	62.5	31.3	16	8	4	2	1	0.5	0.25	0.12	0.004
1 & 2 Ratio A/T	.84	.98	.73	.91	1.2	1.4	1.25	1.5	2	2	6	12	128

sidered as the "success" for that group. The number of successes, ie, identical reports in the remaining ten Pap smears, could then be determined by experiment and the probability of this particular result by mathematical theory. The probability of having x number of successes, ie, reports identical to the first in the batch in n trials (10 in this case), is an application of a binomial experiment.

To qualify as a binomial experiment, four conditions must be met:

- 1) There must be a fixed number of trials, ten in this experiment.
- 2) A success or nonsuccess must result from each trial. Successes for each batch are either 1 or 2 and nonsuccesses are either not 1 or not 2.
- 3) Each trial must have the same probability of success. Sending the smears in batches tends to keep P constant.
- 4) Each trial must be independent of each other. This has been demonstrated to be true.

This experiment, therefore, satisfies all the necessary conditions.

Each experiment consists of ten independent binomial trials each with a probability of $p = \frac{1}{2}$ of success and $(1-p)$ or $q = \frac{1}{2}$ of failure. The probability that the ex-

periment has x successes and 10-x failures in N trials, each with the probability p of success is given by the following notation: $b(x;n,p) = \frac{n!}{x!(n-x)!} \cdot p^x \cdot q^{n-x}$ Where $n = 10$, $p = \frac{1}{2}$ and $q = \frac{1}{2}$ $b(x;10,\frac{1}{2}) = \frac{10!}{x!(10-x)!} \cdot (\frac{1}{2})^x \cdot (\frac{1}{2})^{10-x}$ and P(X) for X between 0 through 10 = $\frac{10!}{x!(10-x)!} \cdot (\frac{1}{2})^x \cdot (\frac{1}{2})^{10-x}$ (10/x) is the symbol for the number of combinations of 10 things taken x at a time.

The purpose of examining this complex mathematics is to show how the calculations can be made and how tedious and laborious it is to actually perform the mathematics needed to calculate these probabilities. Fortunately, this has been simplified by the use of tables in which these calculations have been determined. The results that follow are obtained in this way (Table 4).

The probability of getting as few as two successes or as many as eight successes out of ten tries is only 0.04 and occurred in three of the ten batches. This low degree of probability lessens confidence in the reliability of the reports and supports the author's observation that his results were disproportionate, ie, having an excessive number of ones or twos in a mailing. However, from this data, one can not conclude that the laboratory is subjectively evaluating the slides since

these findings may be due to the series being of insufficient length or to the unique nature of the patients comprising the Pap smear series.

The practicing physician is really asking his clinical laboratory in mathematical language: "Are the reports I receive from you truly representative of a larger series, that is, are they random samples?"

Are the findings of the relatively few slides we send going to result in a random series which can be relied on to be a valid part of the much larger series the clinical laboratory obtains from many physicians?

To determine whether a series is random, the number of successes, nonsuccesses, and runs must be known. If, for a particular number of successes and nonsuccesses, the number of runs found in the series can occur by chance more frequently than once in 20 times, then one can say that the sample is random and can be used for statistical purposes. Probably a more accurate statement would be that if the number of runs could occur by chance more frequently than once in 20 times the sample series was not proven to be nonrandom. If the frequency is less than one in 20, randomness can not be assured.

Fortunately, mathematicians have calculated tables

Table 4

Batch	1	2	3	4	5	6	7	8	9	10
1st report—"success"	1	2	2	1	1	2	1	1	2	2
Number "successes"	6	2	6	8	4	7	8	5	3	4
Number "nonsuccesses"	4	8	4	2	6	3	2	5	7	6
$b(x;n,p) = \frac{n!}{x!(n-x)!} p^x q^{n-x}$	.20	.04	.20	.04	.20	.12	.04	.25	.12	.20
P(success)	0.6	0.2	0.6	0.8	0.4	0.7	0.8	0.5	0.3	0.4
Runs	7	5	3	4	2	4	5	6	5	3
Randomness	no	no	no	no	no	no	no	yes	no	no

for 5% levels of trusts. Through the use of these tables it was found that only one of the ten batches of Pap smears sent to the clinical laboratory could be considered a random sample. From these results three possible conclusions may be considered: 1) Eleven specimens in each batch is too short a series to evaluate; 2) the slides were examined subjectively; 3) the patients in the series were atypical and not sufficiently representative of the larger series.

An attempt was made to study the validity of these conclusions. It was possible to identify the laboratory technicians, R and V, who interpreted 106 of the 110 smears used in our office series. Considering only R's results for the first five batches and then the second five batches yields two acceptable random series. In like manner, V's sequences also showed randomness.

Testing each technician's results for independence $P(A \cap B) = P(A) \times P(B)$, one finds a reasonable degree of agreement. Technician R found $P \cap (AnB) = .43$ and $P(A) \times P(B) = .40$. Technician V found $P(AnB) = .36$ and $P(A) \times P(B) = .33$. However, both technicians' results for their series is far from the theoretical result of $P(A \cap B) = P(A) \times P(B) = .25$.

A study of the runs reported by each technician also shows a significant deviation from the expected results. See Table 5.

As previously stated, only one of the authors ten batches of Pap smears could be con-

Runs	1	2	3	4	5	6	7	8-11	12
Actual (R)	8.5	2.5	0.5	3.5	0	0	1	0	1
Theory (R)	6	3	1.5	0.75	0.37	0.19	0.09		0.003
A/T (R)	1.4	0.8	.2	10	0	0	10		341
Actual (V)	14.5	3.5	1.5	1	1	2	0	0	0
Theory (V)	7.5	3.8	2	1	0.5	0.25			
A/T (V)	2	1	0.75	1	2	8			

sidered as random in distribution. However, if longer consecutive series of these results are examined for randomness, ie, five batches of 22 slides each, then four of the five batches would be considered to satisfy the conditions for randomness.

Therefore, the observation that prompted this study was correct, but only to a limited degree. As the observed series becomes longer the apparent high degree of subjectivity markedly lessens. Since there is no uniqueness to the patients examined, it appears that the most important factor in producing a random series is to have a series of sufficient length, not less than 25 reports.

Discussion

It has been shown that an analysis of a series of 1,000 consecutive Pap smears from a clinical laboratory is reported independently and with little evidence of subjectivity and that the actual findings closely approximate the theoretical results one would expect. It was also determined that groups of 11 smears sent in from an office can not be considered as a random sample. At least 25 reports should be evaluated for randomness to give meaningful results.

The available data was not sufficiently complete to with-

stand critical analysis of the validity of the results. However, the method of approach for examining a technician's results for objectivity, independence, and randomness can be applied to suitable data. One would need the raw or unreviewed results for each technician submitted on a daily basis.

An attempt was made to obtain such data, evaluating two technicians, one considered the more objective and the other a person with wider swings of mood. It would have been most interesting to study their results with the mathematical techniques discussed. Unfortunately, for reasons unknown to the author, this data was not forthcoming. Nevertheless, the principles are clear and perhaps the clinical laboratory will see fit to undertake such an investigation themselves.

Conclusions

After examining 1,000 consecutive Pap smear reports from a clinical laboratory and the results of 110 Pap reports from my office to the same laboratory, the author concludes that the results obtained by the practicing physician can not be proved to be subjectively reported and more likely represent a high degree of objectivity in interpreting the smears by the professional staff of the clinical laboratory.

CURRENT STATUS OF DIABETIC AND SICKLE CELL RETINOPATHIES

ARNALL PATZ MD

Dr Patz is Director, Diabetic Retinopathy Center, Johns Hopkins Hospital, Baltimore.

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Information and reprint requests should be addressed to Dr Patz at the Wilmer Institute, Johns Hopkins Hospital, Baltimore Md 21205.

These two topics are major causes of blindness in this country. Diabetic retinopathy is the largest cause of new adult blindness in this country today. With increasing longevity of the diabetic patient, it is predicted, if no effective method of eradicating the vascular complications of diabetes is developed, that it will possibly be greater than all other causes of adult blindness combined by the turn of the century.

The problem of sickle cell anemia is well known. Somewhere in the range of one million black Americans are afflicted with sickle cell disease, and a large number of these individuals develop retinopathy. Severe visual impairment may result from the retinal vascular complications. It is appropriate to discuss these two major causes of blindness jointly as the proliferative phase of the retinopathy is quite similar in each condition.

Although I will present the technical ophthalmological aspects of these topics with slide material, I hope to make it useful to the internist and the diabetologist by stressing areas where the contribution of the internist is useful in the management of the patient.

Diabetic Retinopathy

Diabetic retinopathy can be conveniently divided into two stages: 1) background diabetic retinopathy and 2) proliferative diabetic retinopathy.

In background diabetic retinopathy, the retinal vascular pathology is contained within the substance of the retina. The lesions observed in background retinopathy are microaneurysms, hard or "waxy" exudates, intraretinal hemorrhages (dot and blot hemorrhages), soft exudates (cotton wool spots), beading of the retinal veins, and retinal edema.

In proliferative diabetic retinopathy, the retinal vascular pathology is no longer contained within the substance of the retina. Here, new vessels break through the internal limiting membrane of the retina to grow onto the surface and proliferate into the vitreous cavity. Hemorrhages occur from these vessels and the subsequent fibrous proliferation and scar tissue with ultimate retinal detachment causing loss of function as does major vitreal hemorrhage.

In patients with background retinopathy, one particular complication deserves special mention. This is the problem of macular edema occurring in the patient with adult-onset diabetes. In these patients with macular edema, permanent changes frequently occur in the center of the macula, leading to significant loss of the central visual acuity. Macular function is compromised and serious loss of reading visual ability results. In our diabetic retinopathy center at the Johns Hopkins Hospital, the largest single cause of reading visual impairment was found to be the macular edema occurring in background diabetic retinopathy of patients with adult-onset diabetes.

The schematic diagrams and photographs illustrate the lesions typically observed in these two stages of diabetic retinopathy (Fig 1-4).

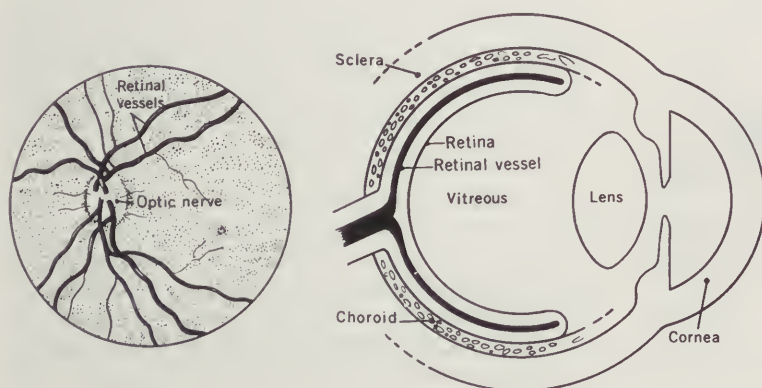


Fig 1. Schematic diagram showing that the retinal vessels in the normal eye are contained within the substance of the retina.

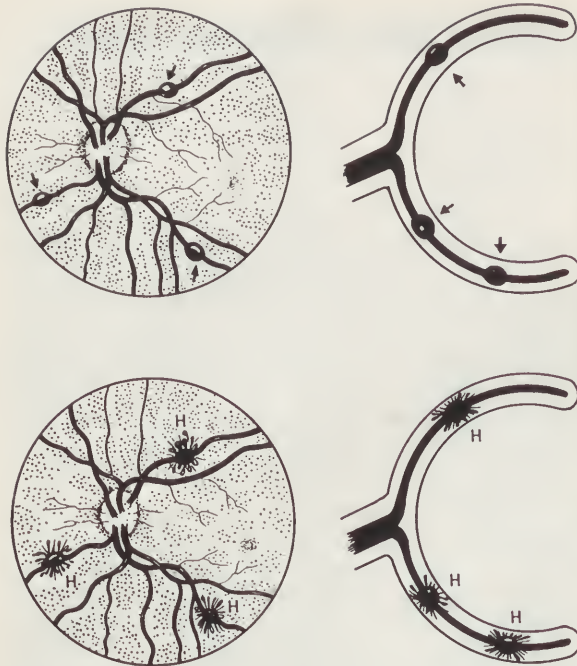


Fig 2. Schematic diagram depicting the microaneurysmal changes of background diabetic retinopathy where the vascular lesions are contained within the retina.

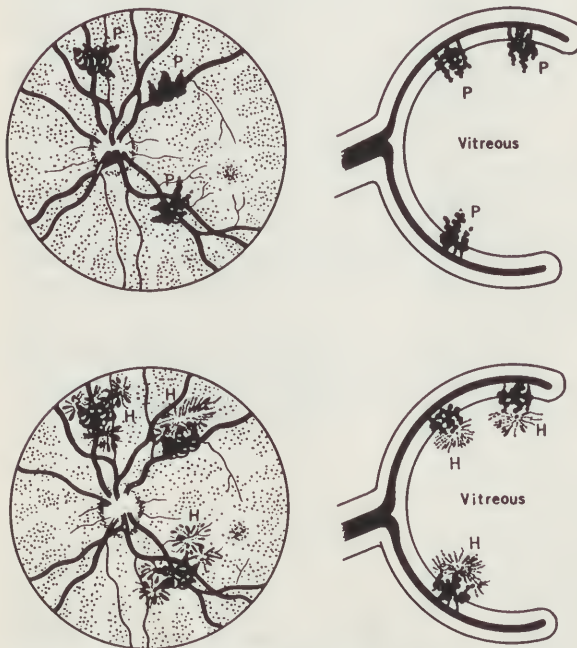


Fig 3. Schematic diagram showing proliferative new vessels growing through the surface of the retina into the vitreal cavity.

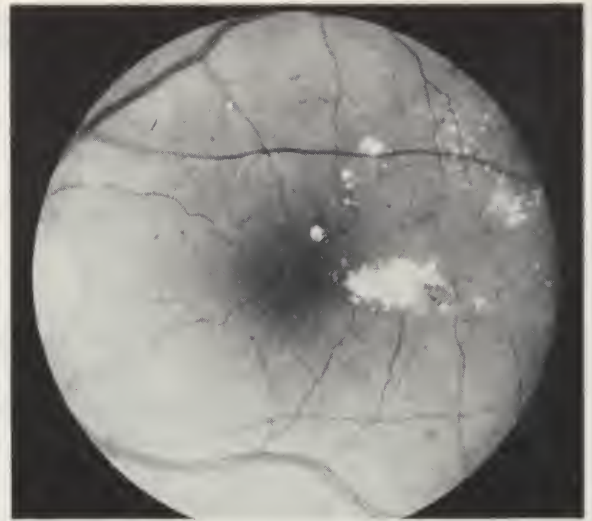


Fig 4. Photograph of the retina on a 43-year-old patient with a history of diabetes of 15 years' duration. Microaneurysms, hard exudates, and small intraretinal hemorrhages are typical of the changes in background diabetic retinopathy. Visual acuity is reduced to 20/40 from macular edema.

Photocoagulation Treatment

The use of selected light energies such as the Xenon arc, and the argon or ruby laser have been used to photocoagulate the vascular abnormalities in patients with diabetes. Controlled studies have demonstrated that photocoagulation is a useful method in the treatment of adult-onset diabetic patients having background diabetic retinopathy with macular edema. Although the treatment was found to be effective, it is important to point out that the treated eye in the controlled study showed a slower rate of deterioration than the untreated eye, or frequently remained stable while the untreated eye continued to deteriorate. Only occasionally was visual acuity improved in this series of patients. The results of this study are important to the internist managing the patient with adult-onset diabetes who shows macular changes. Early detection of these changes and consideration of treatment before more advanced and irreversible changes have taken place is the important guideline for the internist or physician managing the patient's diabetes.

The photocoagulation method has also been used for patients with proliferative diabetic retinopathy. Adequately controlled studies to prove the beneficial effect of photocoagulation in the *proliferative* stage of the disease are still lacking. It is important to point out that, if photocoagulation is ultimately proven to be beneficial to

the patient with proliferative retinopathy, the experience to date shows that treatment for the earliest stages of the proliferative changes carries the best chance of success. The National Eye Institute of the National Institutes of Health has recognized the need for firm documentation of the merits of photocoagulation for proliferative diabetic retinopathy. They have recently sponsored a sixteen-hospital National Cooperative Study to test in a carefully controlled study the effects of photocoagulation in proliferative retinopathy. This study, which involves the random assignment of treatment to one of two eyes of patients with proliferative changes, offers an excellent opportunity to clarify the role of this modality in treatment.

Internists who are following patients with proliferative diabetic retinopathy are encouraged to send them to their ophthalmologist to determine if the patient is a suitable candidate for the National Cooperative Study. It is important for the internist or practitioner managing the patient's diabetes to be aware of this national study as the early recruitment of patients will facilitate the answer to this important question. In addition to establishing whether or not photocoagulation is better than the natural history of proliferative diabetic retinopathy, the national study will provide information on the best type of energy to utilize in the photocoagulation treatment. Leading diabetic retinopathy centers in this country are cooperating in this study and we are quite privileged at the diabetic retinopathy center located in the Wilmer Institute of the Johns Hopkins Hospital to be a participant in this study.

Hypophysectomy

Hypophysectomy has been advocated by several investigators for the more advanced cases of proliferative diabetic retinopathy. With the advent of photocoagulation, there has been a progressively diminishing use of hypophysectomy therapy. There is still considerable controversy on the apparent beneficial effects of hypophysectomy on proliferative retinopathy because of inadequate controlled studies to document its effect. Because of the more significant side effects following hypophysectomy, many investigators feel that the procedure should not be considered under any circumstances until further controlled studies are done. It is important in considering any form of therapy for proliferative diabetic retinopathy to recognize that about 10% of patients with this stage of retinopathy undergo spontaneous regression. The effects of any form of treatment must be carefully weighed against the natural history.

Sickle Cell Retinopathy

There is a definite risk of retinopathy occurring in patients with sickle cell anemia. Several investigators have divided the ocular findings into a clinical classification. The classification adopted by Dr Morton F Goldberg, based on patients followed at the Wilmer Institute, is most commonly used today.

This classification divides the morphological appearance of the eye-grounds into five basic stages:

1) *Stage of vascular occlusion* — Here, the precapillary arterioles are occluded which results in a focal area of retinal ischemia in the area supplied by the involved vessels.

2) *Stage of collateral vessel formation* — in the area of vascular occlusion, collateral vessels will develop shunting the blood in the involved area.

3) *Stage of retinal vasoproliferation* — In the area of retinal ischemia, neovascularization will occur with new vessels breaking through onto the surface of the retina proliferating into the vitreous. This stage of retinitis proliferans is quite similar and, indeed, almost indistinguishable from this type of neovascularization that occurs in proliferative diabetic retinopathy.

4) *Stage of vitreal hemorrhage* — Intravitreal hemorrhages occur from the neovascularization in this stage. The amount of vitreal hemorrhage and subsequent organization of the hemorrhage determines the degree of subsequent change described in Stage 5.

5) *Stage of retinal detachment* — Localized or rather extensive retinal detachments can follow the vitreal hemorrhage and subsequent organization with traction effect on the underlying retina.

The management of the ocular findings in sickle cell retinopathy involves the treatment of the proliferative stage of the disease. When the new vessels are flat on the surface of the retina, the Xenon arc or argon laser works equally well in photocoagulating the vascular lesions. When the neovascularization is significantly elevated into the vitreal cavity, the argon laser has proven considerably more effective in our hands. When traction detachment has resulted, treatment by surgical methods for retinal detachment is utilized.

Summary, Conclusions

Diabetic retinopathy is a major cause of blindness in this country in both white and black Americans. Sickle cell retinopathy is a signifi-

cant cause of visual impairment and blindness in black Americans afflicted with sickle cell anemia. Photocoagulation therapy appears useful in selected cases of both of these conditions and a vitally needed national study on proliferative diabetic retinopathy is in progress to document the true role of photocoagulation in this condition. Further research is urgently needed to develop methods of preventing the complication of retinopathy in both diabetic and sickle cell retinopathies.

The internist or family physician, having responsibility for the general care of the pa-

tient, should be aware of the ocular complications of diabetes and sickle cell anemia and should obtain further ophthalmological evaluation of the patient in the earliest stages of the retinopathy.

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Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

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Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis. In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

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- primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia)
- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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Contraception, Sterilization, and Abortion Legal Interpretation of Consent

D FRANK KALTREIDER MD

Dr Kaltreider is Chairman, Subcommittee on Maternal Welfare of the Committee on Preventive Medicine and Public Health, Medical and Chirurgical Faculty of the State of Maryland.

There have been many recent changes in viewpoints and opinions at both the State and Federal level concerning social obstetrics and gynecology. The legal interpretations given here have been reviewed and approved by John King Esq, legal counsel for the Medical and Chirurgical Faculty of Maryland.

Contraception

In 1971, a Maryland bill was passed and signed into law which states that contraceptive advice may be given to any minor without risk of civil action by parents. This law further extended a 1967 law which permitted the same for pregnancy and venereal disease. Thus, any minor seeking advice concerning contraception implies consent. Sterilization of minors is not permitted except under the unusual circumstances described here.

Sterilization

Maryland is fortunate in not having a law on sterilization except for minors (see below). This procedure no longer has but few medical indications. However, it is the prerogative of any male or any female who desires sterilization to have sterilization available to them, short of minority of the patient. (The Maryland State Law now defines minority as under 18. Anyone 18 or over is considered a responsible adult). The signature of the patient only is required. Sterilization should be on request whether the patient has never been pregnant or has had pregnancies. Counseling prior to the procedure is mandatory. Counseling should include the slight risk of failure, the methods available (male as well as female methods), the procedure with particular reference to the difficulties involved with reversal. In the younger, a waiting period to "think it over" is advisable.

The indigent and medically indigent are at greater risk than those whose medical economy is sound, for they are less likely to know where to seek further help if the physician, hospital, or health worker does not wish to become involved with abortion or sterilization. It would be a kindness to them to be referred to a physician or hospital sympathetic to the patient's desires.

An incompetent person may not give consent

by himself. Usually such person is a mental retardate and it is necessary to document this fact by a psychologist or psychiatrist. Consent from either parent and/or guardian must then be obtained for either sterilization or abortion. Without a medical reason or confirmation of mental retardation, which implies the inability of the patient to take care of his/her own children, sterilization should not normally be done. However, court action is not a prerequisite when adequate reasons are present.

Abortion

Patient: The only requirement of the patient is her desire and request for abortion. Any patient of any age may request. Parental consent is not required in minors because of the Maryland Consent Law which became effective July 1, 1967. Only her signature is required, neither the parent's nor the husband's.

Physician: 1) The usual responsibility of preoperative evaluation including a Pap Smear and the Rh factor, 2) the operative capability, 3) counseling on contraceptive and emotional problems.

Hospitals: 1) Adequate facilities and sufficient equipment in satisfactory repair, 2) the usual operative consent form is all that is required, 3) an abortion review panel is no longer required by either the State Law or by the JCAH, 4) reporting to the State Department of Health and Mental Hygiene is still required.

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MED-CHI Guidelines For Physician Performance of Induced Abortions

Introduction

The following information is provided for physicians of Maryland under which induced abortion on the basis of sound medical judgment shall be performed.

Physician Responsibilities

1) Preoperative Evaluation and Records

An evaluation shall include a) medical history, b) physical examination, c) appropriate laboratory tests, and d) appropriate emotional and contraceptive counseling either pre- or post-operatively.

2) Operator

An induced abortion shall be performed only by a licensed physician who has obstetric and gynecological training and/or is able to demonstrate proficiency in abortion procedures.

3) Proper Facilities

A) During the first 12 weeks of gestation (from the first day of the last normal menstrual period) the abortion may be performed in any facility which protects the health and welfare of the patient and follows the standards established by the Medical and Chirurgical Faculty of the State of Maryland.

B) After the first trimester of pregnancy, an induced abortion shall be performed in a licensed hospital only.

4) Operative Consent

Written consent for the performance of an induced abortion must be obtained from the patient in every case. In case of documented mental incompetency, consent by parent and/or guardian is required.

5) Reporting

All physicians and all licensed hospitals or facilities in which abortions are performed shall make such written reports on all abortions as required by the Secretary of Health and Mental Hygiene. These reports shall not contain the names of the patients aborted. Such information which is not subject to the physician-patient privilege may be made available to the public.

Abortion Surveillance Reports may be obtained from the office of J King B E Seegar Jr MD, Chief, Maternal and Family Planning Section, State Department of Health and Mental Hygiene, 301 W Preston St, Baltimore Md 21201, phone 383-2667.

Refusal

"A) No person shall be required to perform

or participate in, or refer to any source for, any medical procedure that results in termination of pregnancy, sterilization or artificial insemination; and the refusal of any person to perform or participate in or refer to a source for such medical procedure shall not be a basis for civil liability to any person nor a basis for any disciplinary or any other recriminatory action against him.

"B) No hospital, hospital director or governing board shall be required to permit the performance of any medical procedure that results in termination of pregnancy, sterilization or artificial insemination, within its institution; nor shall any hospital, hospital director or governing board be required to refer any person to a source for the performance of such medical procedures; and the refusal to permit such procedures or to refer to sources for such procedures, shall not be grounds for civil liability to any hospital, institution or person nor a basis for any disciplinary or other recriminatory action against him or it by the state or any person.

"C) The refusal of any person to submit to an abortion or sterilization or to give consent therefor shall not be grounds for loss of any privileges or immunities to which such person would otherwise be entitled nor shall submitting to an abortion or sterilization or the granting of consent therefor be a condition precedent to the receipt of any public benefits."

(Article 43, Section 556 E Annotated Code of Maryland)

Adopted by Council June 21, 1973



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STANDARDS FOR OUTPATIENT FACILITIES FOR ABORTION SERVICE

Preface

A copy of these Standards shall be kept available for reference on the premises of outpatient facilities for abortion service. Employees shall be fully informed and instructed with reference to these Standards.

The State of Maryland Fire Prevention Code or Local Fire Code shall be considered a part of these Standards. Conditions not covered in the Section, Fire Protection, shall be met in accordance with accepted fire prevention practices as established by the National Fire Protection Association, State Fire Prevention Code, governing codes, laws, and ordinances.

Purpose

The purpose of these Standards is to provide public health standards of care in the performance of abortions, with proper regard for the health, safety, and well-being of the patient.

Standards

1) An abortion shall be performed in an abortion facility operated in accordance with the provisions of these Standards and fire regulations including electrical and plumbing.

2) Hospital Admission for Emergency Patients—At least one physician on the staff of the abortion facility shall have obstetric/gynecological privileges in a licensed hospital which is located within a reasonable distance of the facility (suggested driving distance two miles or less). Transportation for patients requiring emergency admission shall be available.

3) Admission Requirements—

- a) Abortions on patients with a pregnancy up to and including twelve (12) weeks (from the first day of the last normal menstrual period), as determined by the physician may be performed in an outpatient facility.
- b) Those patients with a pregnancy more than twelve (12) weeks, as determined by the physician, shall be treated as an inpatient in a licensed hospital.

Filing Staff and Service Regulations

An outpatient abortion facility shall be maintained in accordance with a set of formal standards which define the professional qualifications of its medical, nursing, and administrative staffs and which govern the conduct of the service. These standards shall be prepared by the physician in charge of such service and a copy of such standards and any change or modification thereof shall be filed with the Medical and Chirurgical Faculty of the State of Maryland.

Records and Reports

An outpatient abortion facility shall keep records including admission and discharge notes, histories, physical examinations, laboratory results, nurses' work sheets, social service records and contraception and emotional counseling data, and any other appropriate documentation.

Vital Statistics

Abortion facilities shall prepare and submit to the Secretary of Health and Mental Hygiene "Abortion Surveillance Statistical Reports" respecting confidentiality of the patient. Such reports shall be submitted on each patient and shall include all information deemed necessary by the Secretary of Health and Mental Hygiene.

Abortion Surveillance Reports may be obtained from the office of J King B E Seegar Jr, MD, Chief, Maternal and Family Planning Section, State Department of Health and Mental Hygiene, 301 W Preston St, Baltimore Md 21201, phone 383-2667.

Facilities, Equipment, Supplies

Facilities, equipment, and supplies in an abortion facility shall be maintained in proper working order. Necessary IV fluids, drugs, and medications for treatment of shock shall be supplied and maintained. Knee, foot, or elbow-controlled sinks shall be provided in or immediately adjacent to the room where the abortion is performed. The abortion service facility and equipment shall be maintained in a clean and sanitary condition.

Elevators

Outpatient abortion facilities should preferably be located on the ground level, convenient to the street and ambulance entrances.

Any building of more than one story in height and of which an outpatient abortion facility is a part shall provide an elevator for the use of nonambulatory abortion patients. The elevator shall be of sufficient size to accommodate a standard stretcher. When a nonambulatory abortion patient is moved from one floor to another, or to a hospital, she shall be accompanied by attending medical or nursing personnel. A stairway of adequate dimensions shall be available for transfer of a stretcher in case of a power failure.

Admission and Examination Facilities

An outpatient abortion facility shall provide facilities for registration, medical evaluation, examination, and referral, equipped with suitable furnishings and accommodations, including

waiting and dressing rooms and other appurtenances such as public toilets with wash basins, for the physical comfort and convenience of patients and personnel. Sufficient suitably equipped examining rooms shall be provided for the daily caseload.

Laboratory Facilities

The clinical laboratory shall be capable of performing pregnancy testing, urinalysis, hematocrit, or hemoglobin. Policies for all other tests, including the examination of surgically removed tissue, shall be determined by the staff physician in charge and may be forwarded to other laboratories. All patients who are Rh negative insensitive shall receive Rogam or its equivalent.

Operating Facilities

All rooms in which abortions are performed shall be adequately equipped, supplied, and staffed, and shall include the following, in addition to the instruments and equipment needed for the performance of abortions:

Resuscitation equipment and such other equipment as is necessary to treat patients for hemorrhage, shock, and other emergencies. Personnel other than the operator trained in resuscitation techniques should be available.

An adequate supply of drugs, plasma expanders, and parenteral fluids shall be available at all times with appropriate refrigeration equipment.

A licensed nurse with training in operating room techniques shall be in charge of the procedure room with adequate qualified personnel in assistance. The procedure rooms will vary with the size and location of the institution.

Dressing room and scrub-up facilities should be suitably located and should include a scrub sink, soap dispenser, and brushes.

Clean and soiled utility rooms shall be arranged and provided with equipment necessary for proper patient care, including a clinical sink, wash sink, sterilizers, storage cabinets, work counter, and hamper.

A sterile supply room for the storage of all sterile supplies and equipment should also be convenient to the procedure room or operating room.

Medicine cabinets should be convenient to the procedure rooms and should be under lock, and only authorized personnel should have access.

The operating facilities and equipment shall be constructed and maintained so as to be free from sanitary hazards likely to cause a fire or explosion.

Environmental controls to prevent infection, including the control of personnel and patient traffic, shall be maintained in the operating facility.

Techniques

Only operative procedures acceptable to the Medical and Chirurgical Faculty of the State of Maryland shall be performed in outpatient facilities.

Recovery Room or Rooms

An adequately sized and separate recovery room or rooms in proximity to the operating facility shall be provided. The recovery room or rooms shall contain adequate furnishings to provide for the comfort and observation of the patient during the immediate postoperative period.

Staff

The physician in charge of the abortion service should be a trained Obstetrician/Gynecologist and shall be responsible for setting policies, procedures, and establishing standards.

Nursing Staff

The outpatient facility shall be under the supervision of a licensed nurse, preferably one who has had training and experience in obstetric nursing.

She must be currently licensed with the Maryland State Board of Examiners of Nursing.

The supervisor shall be chosen for her training, experience, and executive ability. While patients are in attendance she, or a competent assistant, shall be on duty at all times, together with adequate assistance to assure proper patient care. All nursing personnel shall be qualified for their specific assignments.

Counseling Staff

There should be abortion counseling for individual patients, and this should include information on the availability of family planning services and/or alternatives to abortions, when desired by the patient.

Communication

There must be a telephone in the building with extensions and extra trunk lines as needed, with special emphasis on the importance of calling for help in case of fire or other emergency.

Inspection

The Medical and Chirurgical Faculty of the State of Maryland or its appointed representative shall have the right to inspect any facility in which abortions are performed and any and all records maintained herein at any reasonable time without prior notice.

Adopted by Council June 21, 1973



ROBERT E FARBER MD MPH
Commissioner

Baltimore City health department

Immunization

The City Health Department, in cooperation with the public and parochial schools of Baltimore City, has distributed 150,000 letters to parents of elementary school children urging them to meet the new State school immunization requirements now.

While most children are in compliance, some parents still have not brought the child's immunization records to school or have failed to complete the series of shots required for school attendance.

While our child immunization record surpasses state and national levels due to aggressive campaigns in the past, the Department is still much concerned with trying to have every child in Baltimore protected against these serious illnesses. Your assistance in seeing that every susceptible child is protected is greatly appreciated.

Furnace Study Report

A report on the free home oil burning furnace survey conducted by the City Health Department's Bureau of Industrial Hygiene from January 22 to April 5 this year has just been released. Of the 258 furnaces tested in this period, 107 or 42% were found to be wasting oil through heat loss up the chimney. Nine systems produced stack temperatures above 900 degrees Fahrenheit and were considered potentially dangerous and 170 or 66% were producing excessive smoke and soot. All owners were notified of the results of the tests on their furnaces and advised to correct any defects found.

The new survey is another of the continuing efforts by the City Health Department to assess Baltimore's air pollution problems and to improve air quality. Although the survey has been discontinued for warm weather months, Mr Elkins W Dahle Jr, Director of the Bureau of Industrial Hygiene, says the Division of Air

Pollution Control is planning to resume its furnace testing activities in the fall.

Such tests are showing that furnaces, like any piece of operating equipment, need care and maintenance to perform at their best; good performance means both lower oil consumption by the resident and lower air pollution for everyone. City residents are urged, therefore, to have their heating systems checked, cleaned, and repaired during the months they are not in operation. When the free furnace tests are begun again, any physician wishing to have his furnace tested may do so by calling the City Health Department's Bureau of Industrial Hygiene, 396-4429.



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(Baltimore)
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Psychiatric Day Center Expands

The City Health Department's Psychiatric Day Center has expanded its facilities and moved its administration offices to 2704 N Charles St. Established Oct 1, 1962, the Center assists in preventing the hospitalization of persons with marginal mental and emotional problems by maintaining them in the community with only part-time care. First located at 2111 N Charles St, pressure of space for more working area necessitated a move to 2708 N Charles St in 1968. Now the need for a treatment area apart from the administration office has been realized.

In the latest changes made with the cooperation of patients and staff, the second floors of both 2706 and 2708 N Charles St are combined for both a large day room suitable for patient-staff community meetings and space for other therapy programs not so far above ground level to be taxing for elderly patients. The ground floor of these two buildings is an outpatient clinic operated by North Charles General Hospital that implemented the new construction and maintains the property for the City. These changes will both improve treatment and make possible the acceptance of more patients.

The City's Psychiatric Day Center provides a partial hospitalization program and related services to adult residents of Baltimore City who are moderately to severely psychiatrically ill. These patients may be referred to the facility by professionals, health care facilities, social agencies, private doctors, hospital pre-admission services and lay persons. The Center is open Monday through Friday from 8:30 AM to 4:30 PM and Tuesday evenings until 6 PM. Physicians desiring information about patient admission services and other services may call 396-6061. Director of the Center is Dr John B Herts, psychiatrist.

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By Medical Referral

USE OF PHYSICIAN'S NAME IN COMMERCIAL ADVERTISING

From time to time in the past physicians have permitted the use of their names in commercial advertisements. It was not a widespread, frequent, or accepted practice.

At this time the Council sees definite evidence of a break with ethical tradition. Commercial advertisement carrying the name, photograph, and professional appointments of physicians are conspicuous in both public and professional periodicals.

Regardless of disclaimers and alleged educational claims for the ad, the intent of using a physician's name and photograph in an advertisement is simply to draw attention to the ad. The physician who permits his name and photograph to be so used is permitting himself and his profession to be exploited.

The Judicial Council has previously stated that it is demeaning to the medical profession for the physician to permit the use of his name and professional status in the promotion of commercial enterprises. Out of respect for his profession, a physician should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

To the extent that the facts of a particular case indicate that the honor and dignity of the profession are denigrated then charges of conduct contrary to Section 4 of the Principles of Medical Ethics should be brought before and fully reviewed by the ethics committee of the physician's component medical society.

Circumstances will suggest and facts disclose whether some consideration of value was given the physician for the use of his name and photograph by the advertiser. Circumstances will indicate the purpose of the advertisement.

In view of the proliferation of advertising of this nature, the Judicial Council reaffirms its opinion:

It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

In conclusion, the Council condemns as unethical the action of the physician who is found to place personal, selfish, financial, or venal interests ahead of the high ideals of the medical profession. The Council wishes to call this reaffirmation of its opinion to the attention of all physicians and to all ethical medical publications.

Adopted by the AMA Judicial Council, April 28, 1973

Washington County Medical Society News

The Washington County Medical Society was saddened by the loss of one of its outstanding members, Dr Archie R Cohen, who passed away March 7, 1973. Dr Cohen had lived and practiced in Washington County since 1937. Apart from his exemplary practice and devotion to his patients, he made many contributions as President of the Washington County Medical Society, President of the Washington County Hospital Staff, and President of the Maryland Academy of Family Practice. He will be missed by his many grateful patients and colleagues.

On March 22, the Society was privileged to have as their guest Dr DeWitt E DeLawter, then President of the Medical and Chirurgical Faculty of Maryland. He spoke briefly on PSRO and the Faculty's activities in that area. Dr DeLawter is a native of Washington County.

The annual ladies' night was held on May 24 at the "Venice." Members of the hospital board and hospital trustees were invited guests. Mr Gerald Egelston, author and lecturer, of New York City, was the guest speaker.

Five new members joined our Society in July. They are: Dr Edward B Byrd, Neurosurgeon, who will be associated with Dr A F Abdullah; Dr Wilmer Keener, Ophthalmologist, who will be associated with Hager Eye Specialists; Dr Robert Hobbs, Orthopedic Surgeon, who joins Orthopedic Associates; Dr Massoud Alizadeh, who begins General Practice in Clear Spring; and Dr Francis H Cost, who will start his practice in Internal Medicine.

A F ABDULLAH MD
Journal Representative

Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

[†]For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



M-M-R^{*}

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

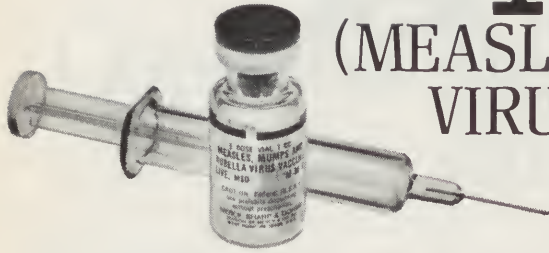
M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies	
Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT ¹
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

^{*}Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.



M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID₅₀ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID₅₀ of mumps virus vaccine, live, and 1,000 TCID₅₀ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

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Special Libraries Association Conference, June 1973

Looking back at the SLA conference in Pittsburgh, the outstanding development was the fact that the Biological Sciences Division seemed to raise its head and offer some programs with substance. The first luncheon meeting featured as speaker Dr Joseph Buckley, Associate Dean, School of Pharmacy, University of Pittsburgh. His subject was "Environmental stresses and their relationship to disease." He illustrated his speech with examples of animals subjected to intermittent exposure to variable stresses.

The business meeting of this division was another luncheon meeting at which the question of a publication was explained and debated. *The Reminder*, the former official publication of the group, requires advertising while a newsletter can be financed out of dues from the 630 members. One newsletter was published this spring and carried four pages of Association and Division news, plus the program and ballot for officers for 1973-1974. Results of the balloting were: Chairman, Caroline Morris; Chairman-elect, Tom Basler, Secretary-Treasurer, Marie Harvin; Directors, Joanne Crispen and Robert Lentz.

One of the most interesting meetings took us into the realms of ESP, a real digression from the usual library subjects. The science writer for the *Pittsburgh Post-Gazette*, Henry W Pierce, gave a history of ESP, ending with several examples of individual experiences. This was followed by a session of *The Growth of Medline* by Grace Jenkins, National Library of Medicine, and *Do Librarians Prevent or Promote Entropy in Information Networks?* by David A E Shephard, Mayo Foundation.

The final meeting of this group was a tour to Hunt Botanical Library and an outdoor lunch at Old Economy.

During the drive we were shown various other

libraries and I later visited the Falk Library of the Health Professions, University of Pittsburgh Medical College, where I was given a personally guided tour by the director, Dr Carroll Reynolds. Their History of Medicine Section is soon to occupy quarters now under construction within the present building.

The highlight of entertainment was the banquet at which awards were announced and the Pittsburgh Tamburitans performed. This is a group of scholarship students who study the music, songs, instruments, and dances of their Yugoslav, Croatian, Slovenian, and Serbian ancestors. Their entertainment accompanied an international menu, with dolls in national costumes on each table.

Aside from a very full program happening in four hotels, sometimes simultaneously, the conference moved smoothly and showed an enormous amount of planning for a small SLA chapter.

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ANESTHESIA

- WO **Anesthesia in thoracic surgery.** Edited by Olof
200 P Norlander. Boston, Little Brown, 1972
.A5

BIOCHEMISTRY

- QK Symposium on the Chemical Composition of
866 Tobacco and Tobacco Smoke, Washington,
.T6 1971
.S9 **The chemistry of tobacco and tobacco smoke.**
New York, Plenum Press, 1972

CHILDREN'S DISEASES

- WL Brain Tumor Symposium, Columbus Ohio,
358 1970
.B8 **Recent advances in brain tumor research.** Basel,
New York, Karger, 1972
WS Crosse, Victoria Mary
410 **The preterm baby and other babies with low**
.C8 **birth weight.** Baltimore, Williams & Wilkins,
1971

DENTISTRY

- WU Friedman, Jay W
100 **A guide for the evaluation of dental care.** Los
.F8 Angeles, 1972

DERMATOLOGY

- WR Association of Professors of Dermatology
22 **Dermatology residency training in the United**
.DA2 **States and Canada n.p.** 1972
.A8
WR Samman, Peter D
475 **The nails in disease.** London, Heinemann Med-
.S1 ical, 1972

EAR

- WV Baru, Alla Vladimirovna
270 **The brain and hearing.** New York, Consultants
.B2 Bureau, 1972

EMBRYOLOGY

- QS Apgar, Virginia
675 **Is my baby all right?** New York, Trident Press,
.A6 1972

EYE

- WW National Center for Health Statistics
141 **Eye examination findings among children.** US
.N3 Govt Print Off, Washington, 1972

GASTROINTESTINAL SYSTEM

- WI Urgent endoscopy of digestive and abdominal
141 diseases. Edited by Z Maratka and J Setka.
.U8 Basel, New York, Karger, 1972

GYNECOLOGY

- WP Cohen S Joel
468 **Abdominal and vaginal hysterectomy.** Phila-
.C6 delphia, Lippincott, 1972
WP **Gynecological oncology.** Edited by Hugh R K
322 Barber and Edward A Graber. Amsterdam,
.G9 New York, Excerpta Medica Foundation,
1970

- WP International Symposium on Vulvar Cancer
200 **Aspects and treatment of vulvar cancer.** Basel,
.I6 New York, Karger, 1972

- WP Niswander, Kenneth R, 1924-
18 **Obstetrics and gynecology.** Flushing NY, Med-
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HEART

- WG Schneider, Daniel Edward, 1907-
300 **Psychoanalysis of heart attack.** New York, Dial
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HEMIC AND LYMPHATIC SYSTEMS

- WH Shields, Jack W
700 **The trophic function of lymphoid elements.**
.S5 Springfield Ill, Thomas, 1972

**HOSPITAL ADMINISTRATION
AND ORGANIZATION**

- WX **Evaluation of care in the university and com-**
153 **munity hospital.** Edited by James E C Wal-
.E9 ker, Dorothy J Douglas and Wesley M
Vietzke, Harford Conn. New Haven, 1971
ZWX US Health Care Facilities Service
150 **Publications of Health Care Facilities Service.**
.U5 US Govt Print Off, 1972

HOSPITALS

- Ref. **AHA guide to the health care field.** 1972-
WX Chicago, American Hospital Assn v Continues
22 Hospitals: guide issue.
.AA1
.A5
WX National Center for Health Statistics.
16 **Inpatient Health facilities as reported from**
.N2 **the 1967 MFI survey.** US Govt Print Off,
Washington, 1972
WX **The need and feasibility of establishing a hos-**
28 **pital in Howard County, Md.**
.AM3 Submitted by Herbert W Lapp MD Chairman
.H7 of the Howard Hospital Planning Advisory
Board, 1972
WX Spencer, James H
215 **The hospital emergency department.** Spring-
.S7 field Ill, Thomas, 1972



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INDUSTRIAL HEALTH AND HYGIENE

- WA **Industrial environmental health.** Edited by
400 Lester V Cralley. New York, Academic
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INFECTIOUS DISEASES

- WC **Australia antigen.** Edited by James E Prier and
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450 **Human infection with fungi.** New York,
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- W **Behavioral sciences & medical education.**
18 National Institute of Child Health and Human
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ton, 1972
- W **The challenge of life.** Edited by Robert M
20.5 Kunz and Hans Fehr. Basel, Birkhäuser,
.C4 1972
- W **Humanistic perspectives in medical ethics.**
50 Edited by Maurice B Visscher. Buffalo, Pro-
.H8 metheus Books, 1972
- W Storey, Patrick B
21.5 **The Soviet feldsher as a physicians' assistant.**
.S8 Bethesda Md, National Institutes of Health,
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- W Symposium on Death and Attitudes toward
62 Death, University of Minnesota, 1972
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Bell Museum of Pathology, 1972
- W US Office of Audiovisual Educational Develop-
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.U5 **Media and Health manpower.** Atlanta, 1972

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- W **Medical care for the aging in Maryland.** A col-
275 lection of items related to the Kerr-Mills Act
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- W Fry, John
100 **Medicine in three societies.** USSR, USA and
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MEDICINE

- WB National Center for Health Statistics.
50 **Physician visits.** United States, 1969
.AA1
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MUSCULOSKELETAL SYSTEM

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102 **Brain mechanisms in sensory substitution.** New
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31 **Home care for persons 55 years and over.** US
.N2 Govt Print Off 1972
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31 **From Student to RN.** Supt of Docs, US Govt
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- WQ Boston, Children's Hospital Medical Center
150 **Pregnancy, birth & the newborn baby.** Boston
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350 **Correction of subnormal vision,** 2d ed. London,
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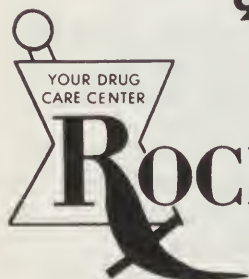
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 900 A study of infant mortality from linked rec-
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 620 **Biological effects of whole — body gamma**
 .D3 **radiation on human beings.** Baltimore, Johns
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 28 **Early years of the McLean Hospital.** Boston,
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 1971
 Z Medical Research Library of Brooklyn
 675 **Rare books in the collection of the Academy of**
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PRINCIPLES OF CLINICAL ELECTRO-CARDIOGRAPHY, by Mervin J Goldman MD, Lange Medical Publications, Los Altos Calif, 1973

The eighth edition of this publication speaks well for its acceptance in medical circles. Perhaps the only new item included is the subject of bundle of His recordings, as well as an expansion of the section on intraventricular defects.

This is an excellent publication for the cardiologist, internist, and medical libraries.

CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY, 15th ed, by Joseph G Chusid MD, Lange Medical Publications, Los Altos Calif, 1973

This volume is intended for the beginner in clinical neurology. It is meant to serve as an aid or supplement to standard neurologic texts and literature rather than as a substitute for them.

The author attempts to present briefly and clearly some of the important structural and functional features of the nervous system as they relate to problems encountered in clinical neurology. Concise format, charts, diagrams, and illustrations have been prepared with this purpose in mind and efforts have been made to include recent important advances in neurology.

REVIEW OF PHYSIOLOGICAL CHEMISTRY, by Harold A Harper PhD, Lange Medical Publications, Los Altos Calif, 1973

This review provides a compendium of those aspects of chemistry that are fundamental to the study of biology and medicine. One of the features of its success since the first edition in 1939 has been the opportunity to revise it to include the latest contributions in the field.

Readers will continue to be served whether they are gaining an introduction to the subject

or are preparing themselves for examinations of state or specialty boards.

REVIEW OF MEDICAL PHYSIOLOGY, by William F Ganong MD, Lange Medical Publications, Los Altos Calif, 1973

This book is written primarily for those who have some knowledge of anatomy, chemistry, and biochemistry. Examples from clinical medicine are given, where pertinent, to illustrate physiologic points.

It effectively gives a concise summary of mammalian and, particularly, of human physiology which medical students and others can supplement with readings in current texts, monographs, and reviews. Pertinent aspects of general and comparative physiology are also included. Summaries of relevant anatomic considerations are found in each section.

SYNOPTIC FUNCTIONAL NEUROANATOMY, by Wendell J S Krief, PhD, Brain Books, Evanston Ill, 1973

This book represents a synopsis of neuroanatomy illustrated by synthetic color reconstructions that should be adapted to all students who may need or wish to know something of the human brain.

It is divided into three descriptive sections, all using the same illustrations. These sections are directed towards different persons involved in the health care field. Section 1, for instance, is intended to fit the needs of paramedical psychology and biology students. Section 2 is for the psychologist, the physiotherapist, and speech therapist. Section 3 is intended for medical students and physicians.



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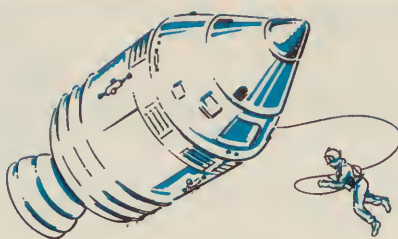
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"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25

should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are *concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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DANIEL V LINDENSTRUTH MD
Editor

A service of the Heart Association of Maryland

the heart page

THE MARFAN SYNDROME

JOHN J MESSINA MD

Dr Messina is Instructor in Medicine (Cardiology), University of Maryland Hospital; also Co-director, Coronary Care Unit, Saint Joseph Hospital, Towson.

In 1896, Antonine Bernard-Jean Marfan (Parisian professor of pediatrics) first described the gross skeletal manifestations of the syndrome that bears his name. He called the condition dolichostenomelia (long, thin extremities). To his initial description were added the additional features of arachnodactyly and ectopia lentis by Achard and Boerger. In 1931, Weve first demonstrated the heritable nature of the syndrome, and its transmission as a dominant trait. The cardiovascular manifestations of this syndrome were first clearly described by Baer and associates in 1943. Since that time, numerous reports have appeared in both the medical and surgical literature, and at present the Marfan syndrome is clearly recognized as one of the heritable disorders of connective tissue.

Age, Sex, Ethnic Distribution

Since the Marfan syndrome is a heritable disorder, it has been reported in all age groups. There is no sex predilection; however, the aortic complications do seem to occur more frequently in men. There is no racial or subracial concentration of cases.

Inheritance and Pathology

The pattern of inheritance is that of a simple Mendelian autosomal dominant. The basic pathologic defect is thought to reside in the connective tissue (primarily elastic and collagen fibers), although no specific histologic abnormality has been detected to date. In the media of the aorta and pulmonary artery the early changes are those described by Erdheim as cystic medial necrosis. There is mild- to moderate degeneration of the elastic fiber elements, with more or less striking cystic areas filled with metachromatically staining material. Changes in the heart valves have been described as marginal

thickening or fibromyxomatous degeneration. An increased urinary hydroxyproline (an amino acid unique to collagen) excretion has been noted in many cases, but is a nonspecific finding since many conditions of increased growth are accompanied by elevated urinary hydroxyproline.

The Marfan syndrome embraces numerous associated lesions of the musculoskeletal, ocular, and cardiovascular systems.

Musculoskeletal

The major musculoskeletal lesions include dolichostenomelia arachnodactyly, increased height (with characteristic lower segment measurement in excess of the upper segment), pectus excavatum, kyphoscoliosis, high arched palate, arm span in excess of height, hyperextensibility of the joints, habitual dislocation of the hips, hernias, muscular underdevelopment, and sparse subcutaneous fat.

Ocular

Ectopia lentis is the major ocular manifestation and is almost always bilateral and due to redundant, attenuated, or broken suspensory ligaments. In addition, myopia, iridodonesis, and spontaneous retinal detachment are often present. The pupil is often difficult to dilate, and the dilator muscle is often hypoplastic.

Cardiovascular

The cardiovascular abnormalities (as well as the musculoskeletal and ocular) are due to a primary defect in connective tissue. This results in weakness and disruption of the media of large- and medium-sized arteries as well as a peculiar type of mucinous and/or myxomatous degeneration of the cardiac valves and the supporting valve apparatus (eg, annulus, cordae tendinae, etc). Accordingly, the following conditions have frequently been reported: saccular dilatation of the main pulmonary artery and its branches, saccular dilatation of the aorta (especially the ascending arch) and its major branches, upward displacement of the coronary ostia, generalized cardiomegaly, cardiac arrhythmias and

conduction disturbances. The most commonly reported associated congenital cardiac defects are coarctation of the aorta and secundum-type atrial septal defect.

Acute dissecting aneurysm of the ascending aorta and arch is one of the major complications, and has been found to be the most frequent cause of death in reported autopsy series. This has usually been reported in males, but is not an infrequent finding in females during pregnancy. It is found in all age groups from infancy to old age. Due to the basic defect in connective tissue (resembling a variant of Erdheim's cystic medial necrosis) the aorta is extremely friable, and therefore the reported surgical mortality is extremely high.

During the past decade, much attention has been focused on nonrheumatic causes of mitral insufficiency. The Floppy Mitral Valve syndrome, Papillary Muscle Dysfunction syndrome, Billowing Mitral Valve syndrome, Blue Valve syndrome, Myxomatous Degeneration of the Mitral Valve, etc are now well described in the literature as causes of mild-to-marked mitral insufficiency. Also, mitral valvular insufficiency (due to myxomatous degeneration of the valve and its supporting structures) has recently been reported in the Marfan syndrome. Several reports stress the acute surgical emergencies encountered; eg, rupture of the chordae tendinae, ruptured aneurysm of the mitral valve, marked prolapse of the posterior leaflet. Phornphutkul et al, at the Children's Hospital Medical Center in Boston, recently reported their entire experience with the Marfan syndrome between 1945 and 1970. They found that cardiac abnormalities were present in 61% of the 36 children studied, and were the leading causes of death. Mitral regurgitation was the most frequently encountered cardiac lesion (47%), occurring in both males and females.

Partial valve detachment is a very frequent complication of valve surgery in patients with the Marfan syndrome, and accounts for the very high surgical mortality which is reported. Since the valve annulus itself is frequently involved in the degenerative process, postoperative suture avulsion and valve detachment is a constant concern to both the surgeon and the cardiologist. Moreover (due to the mucinous and/or myomatous degeneration previously described), plastic repair of the valve is surgically impractical.

EKG Findings

There are no pathognomonic EKG changes. Not infrequently however, ST-T changes inferolaterally are found in association with left atrial hypertrophy and atrial tachyarrhythmias in patients with mitral insufficiency. Also, first degree atrioventricular block and nonspecific intraven-

tricular conduction delays have been reported in association with cystic degeneration of the media of the coronary arteries.

Summary

The Marfan syndrome is a heritable disorder of connective tissue which has no age, sex, or racial predilection. Three major systems are involved: Cardiovascular, Musculoskeletal, and Ocular. The cardiovascular system may be involved to a severe degree at any age; its involvement accounts for the major cause of death in all age groups. The major cause of death is acute dissection and rupture of aneurysms of the aortic arch. Marked mitral valvular incompetence with refractory congestive heart failure also is associated with a high mortality rate. Despite surgical intervention, mortality is very high when such patients present as acute surgical emergencies.

Since propranolol and reserpine are agents which decrease myocardial contractility and diminish the pulsatile flow stress on the weakened aorta, several authors advocate their use in patients with early aortic changes. Otherwise, there are no medical modalities currently available other than cautioning such individuals to avoid contact sports and vigorous physical exertion. Also, due to the higher than expected incidence of dissecting aneurysm of the aorta in pregnancy, it may be wise to consider birth control for women with the Marfan syndrome.

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"A niche of usefulness and self-respect exists for every man, however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave 'he cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work."

John Galsworthy

FREDERICK J BALSAM MD
Editor

rehabilitation medicine

FACIAL PALSIES — FOLLOW-UP STUDY

MARGARET M KENRICK MD
J A LONG BA
G B CORN BA

Dr Kenrick is Professor and Chairman, Department of Physical Medicine and Rehabilitation, Georgetown University School of Medicine, 3800 Reservoir Rd NW, Washington DC 20007.

Messrs Long and Corn are medical students at Georgetown.

Information and reprint requests to Dr Kenrick.

Sir Charles Bell originally attributed facial muscle paralysis to various causes including ear disease, trauma and tumor.¹ Today, the concept of Bell's palsy has changed. If anything, the facial paralysis of known cause is less apt to be called a Bell's palsy. Rather, the unilateral, idiopathic, spontaneous facial palsies are now known as Bell's palsy.

This is a follow-up study on 221 patients with facial nerve palsies who were evaluated and treated at Georgetown University Hospital over a 15-year period between 1956 and 1971. Of this number, 107 were left-sided and 114 were right-sided. For obvious reasons, we will separate the group of known etiology from the idiopathic group. Those with obvious etiologic factors are as listed in Table 1.

Table 1: Etiologic Factors

Fracture involving facial canal	5
Lacerations	4
Parotidectomies	4
Acoustic neuromas	3
Mastoidectomy requiring sacrifice of nerve	1
Metastatic lesion	1
Total	18

The remaining 203 will be considered Bell's palsy. In a study made at their final evaluation, the patients were separated into four groups according to the Mayo Clinic classification.² See Table 2.

The Georgetown statistics correlate quite well with the Mayo statistics. However, the Georgetown statistics are from the Department of Physical Medicine and Rehabilitation and may have

Table 2: Statistics on Recovery

Group	# Patients		George-town	Mayo
I	51	No residua	25%	24%
II	102	Minor residua	50%	48%
III	26	Residua detected on exam	13%	14%
IV	24	Obvious residua	12%	14%

a built-in bias, as not all Bell's palsies would have been referred here but rather only those which did not appear to be improving.

Of these 203 cases, there are several recurring prodromata which deserve some consideration. They are listed in Table 3.

Table 3: Prodromata

	# CASES
Loss of taste	21
Earache	5
Mastoid pain	5
Upper respiratory infections	5
Ear infections	4
Headache	3
Numbness of face	3
Dislocation of temporomandibular joint	3
Hypertension	2
Infection or oral medication 1 day prior	2
Tooth extraction or tonsillectomy 1 week prior	2
Numbness of tongue	1
Use of DDT	1

The systemic diseases that were noted were myxedema in two and diabetes mellitus in seven patients. One of the patients with diabetes had a palsy on the right side in 1965 and on the left in 1967, both of which recovered completely. The remainder of the diabetics fell heavily in Group III and IV and had other factors present such as pregnancy and blindness.

There are some pertinent findings in the relationship of pregnancy to Bell's palsy. Of this group of 203, there were ten closely related to pregnancy. There was one in the first trimester of pregnancy and there were three, one of whom was diabetic, who had their onset early in the third trimester of pregnancy. There was one diabetic and one nondiabetic one week prior to

Caesarean section. Two developed five days prior to a normal spontaneous delivery and two within one month post-partum. Other authors have felt that there is no more than a coincidental relationship between pregnancy and Bell's palsy but these findings seem to indicate more than a casual relationship between the two. Adour³ stated that diabetes mellitus occurs no more frequently with Bell's palsy than it does in the general population but diabetes is an adverse prognostic feature as denervation remains in a far higher percentage. Add pregnancy to this and the prognosis appears to be worse.

The relationship of Bell's palsy to herpes zoster should be noted. There were five cases occurring on the same side of the head from one day to nine weeks prior to the paralysis.

Loss of taste has been related to the prognosis in facial palsy. The data on these patients appear to show no obvious relationship. One of these had a recurrence when she developed the flu, but, again, it cleared spontaneously. Only one of these persons noted a loss of taste one week prior to the onset of Bell's palsy. It is worth noting that, on questioning, many patients state that they noticed no loss of taste. On specific testing, however, either with electrogustometry or putting a drop of sugar, acid, salt, or sour on the anterior two thirds of the tongue on the side of the facial involvement, they will be found to have a true loss of taste of which they were not aware.

There were eight patients who had multiple episodes. All of these palsies were at least two years apart. Six of these had one right and one left side involvement and two of them had repeats on the same side. There was one unusual case that had Bell's palsy two times on one side and three times on the other. This was over a period of 14 years. The patient always had a quick and complete recovery. She first had this at 18 years of age and the last time had it at 33 years of age.

There was no obvious sex differentiation in this group of Bell's palsy but there appeared to be an age distribution as seen in Table 4.

Table 4: Age Distribution

YEARS	LEFT	RIGHT	TOTAL
0-10	4	8	12
11-20	8	11	19
21-30	31	29	60
31-40	14	16	30
41-50	17	11	28
51-60	10	9	19
71-80	5	6	11

In the breakdown on the percentage of recovery in these patients we have found a scatter pattern; ie, the prognosis did not appear to be worse in any specific age group. Some of these patients go back to 1956 when they were not sent to the Department of Physical Medicine and Rehabilitation unless medical treatment had been to no avail and they were at least one month post-onset.

The most common medical treatment given was thiamin, vitamin B 12, intravenous nicotinic acid, and steroids. From the pattern noted in these patients, there was no obvious mode of medical therapy that appeared any better than the other. Some of these patients had dramatic improvement with steroids and others showed no effect. In recent years we have been able to get the patients in early for prognostic testing. A comparison of results from the 1956 through 1967 group showed no difference in percent of recovery than that found in the group formed since 1968. In reevaluating these patients, an objective evaluation showed far less recovery than what the patient subjectively felt was his result. Those who were willing to come back for long-term follow-up were the most severely involved with the least return of function.

A common finding was the presence of "associated movements." These were primarily in the form of a twitch which involved the entire side. This was present without the knowledge of the patient in most cases and was more severe in the cases which had more residua. It was less pronounced in patients evaluated over the last five years who had been warned of the possibility of this developing if they did not continue their exercises and their training before a mirror. From experience it would seem that this twitch originates in the patient as he is getting return of function and is constantly trying out his muscles to see whether they are continuing to improve. Probably the best test for complete recovery is to see whether the patient can wink without closing the uninvolved eye or causing a twitch on the involved side of the face. If he can wink well, there is little or no residua.

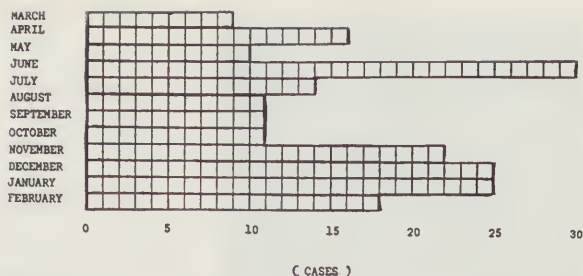
After initial testing, the treatment generally planned for these patients in the Department of Physical Medicine and Rehabilitation consists of radiant heat to the mastoid process for about 30 minutes using a moist pad over the eye, electrical stimulation giving six to ten visible contractions to each one of the involved muscles, a home program of exercises which the patient is to do in front of a mirror regularly and upward stroking facial massage.

After a few weeks of therapy during which the patient has learned to tolerate electrical stimulation, he is transferred to a home program using a rented electrical stimulator. He will then be checked at intervals. Once return appears to be almost complete, the patient is advised to do mirror exercises consisting of normal, routine facial activities such as speaking in front of a mirror so he can transform the isolated exercises into normal function. If this is not done, very frequently the patient will move the muscle fairly well in an exercise program but will not use it in the ordinary everyday facial expression.

The authors also recommend generalized rest in the care of Bell's palsy. Two specific incidents demonstrate why. A senior dental student and a law student each developed Bell's palsy in the winter. The dental student was taking final exams and the law student had to take his bar exam. Each was advised about the importance of generalized rest of eight hours at night and one hour of rest in the middle of the day. Each stated that this was impossible due to the requirements of cramming for finals. For six full months there was no return of function whatsoever. It was not until May, when the pressure was relieved and rest was possible, that each of these patients started making excellent recovery. This was critical since each would be facing the public frequently and cosmesis was important.

In general the recovery time of patients falls into two categories: the early improvement which occurs in the first three to four weeks and the later ones which generally take up to eight months. In the 203 cases there were only three patients who had been decompressed. These were done between the second and third month post-onset after conduction latencies in the facial nerve were not obtainable and the prognosis was poor electromyographically. These had some return after surgery but still had obvious residual paralysis. None had complete return. A similar option was discussed with eight other patients but they preferred to try conservative therapy.

At the present time we are doing conduction latencies in the first week of onset as a major prognostic test. Previously we did chronaxies. It is interesting to note that many of the patients improved to the point where there were no, or only minor, residual and yet chronaxies remained slightly elevated upon follow-up several years later. The motor latency of the facial nerve is normally below 3.5 msec. Within three or four days one can see these latencies elevating and finally obtaining no end point if the palsy



is severe. If the latency is elevated but can be obtained, the prognosis is much better for recovery without surgical intervention.

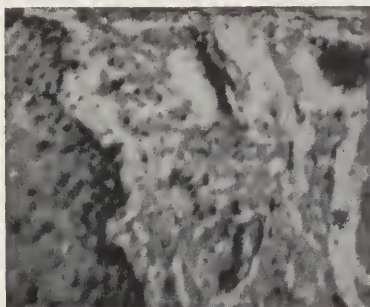
A final additional correlation was made to try to relate the incidence of idiopathic Bell's palsy to the time of the year. See Fig 1. From the graph there are noted two major points of interest: 45% of all Bell's palsies occur during the four winter months, November, December, January and February. This would tend to indicate cold temperatures as a factor. However, the greatest incidence of cases in a single month occurred in June which may be due to the marked increase in turning on air conditioners during this month. Spring, late summer and fall tend to be the lightest times of the year.

In this study we have looked at various aspects of Bell's palsy as seen in 203 cases spanning a 15-year period. There is a wide spectrum of residual found on follow-up study ranging from obvious muscle weakness to a barely perceptible muscle tic or twitch. The degree of recovery appears to be related to the many factors discussed, with this conclusion: the shorter the duration of paralysis, the better the recovery.

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THE PLACE OF THE CLINICAL LABORATORY IN DRUG ABUSE

VICTOR ALBITES MD

Dr Albites is Associate Director, Department of Laboratories, South Baltimore General Hospital.

It had been a quiet night in the Metropolis General Hospital's emergency room; just the usual minor lacerations and illnesses. Then, at about 3:00 AM, the scream of an ambulance siren is heard coming down the emergency room drive. The ambulance slams to a stop. Immediately, the rear doors open. The attendants carry a 15-year-old, unconscious male on a stretcher to an examining room where the waiting physician makes a quick initial examination. Respirations and other vital signs are still present with no signs of obvious trauma. The sketchy history from the attendants is that the youth was found unconscious in an alley by a patrolman with no signs of violence about the site. No identification is found in his pockets to allow contacting parents or friends; no Medic-Alert bracelet to warn of diabetes or other pre-existing conditions. Why is he unconscious; could drug overdose be involved?

With increasing frequency, the physician is faced with the patient presenting with signs and symptoms of possible drug abuse. Drs Sapira and McDonald (Drug Abuse - 1970, Disease-a-Month, Nov 1970) define drug abuse as "the excessive self-administration of chemicals in the hope of producing a condition in the user that he will perceive as more pleasant (or less uncomfortable) than his usual status." The key word is "excess." With drugs like heroin, even one injection may be an excess.

This abuse ranges from accidental poisoning, especially in young children, to use of drugs for nontherapeutic purposes, to overdose with suicidal intent. In a large metropolitan Baltimore hospital, 700 patients per year (on the average) are seen in the emergency room for various toxicologic problems. Some form of drug

overdose was present in 43% of these cases; 20% of the 700 cases involved acute alcoholic intoxication. Narcotism or dependence on other CNS drugs was responsible for 24% of these emergency room visits. According to the statistics of Maryland Poison Information Center, there were 485 cases of ingestion of tranquilizers and barbiturates in Maryland in 1972. In that same year, 255 poisoning deaths were recorded. Of these, 33 were due to barbiturates and 83 were narcotics-related. Seven deaths were due to psychotropic drugs.

The above authors list the abused chemicals in the following categories:

- 1) Drugs of the morphine type (narcotic analgesics)
- 2) Drugs of the barbiturate type (hypnotic-sedatives)
- 3) Sympathomimetic drugs
- 4) Hallucinogenic drugs

What part can the laboratory play in helping the physician evaluate patients abusing these drugs? What specimens should be obtained to send to the laboratory? What information should accompany these specimens to help the laboratory in its handling of these specimens?

In patients with life-threatening symptoms from drug overdose, diagnosis of the specific drug (s) involved must be based on clinical evaluation; laboratory tests for specific drug (s) are not generally available or are too time consuming to be of immediate help. Laboratory tests for drugs are useful in screening suspected drug abusers and in the acute toxic patient to obtain an accurate drug etiology and base-line level. Urine and blood are the usual specimens obtain-

ed, though analysis of gastric contents can be helpful. Urine drug detection is of diagnostic value while blood is of both diagnostic and therapeutic value since drug concentrations can be measured on blood.

Until recently, analytical toxicology had to rely on the microscope for crystal identification, the melting point apparatus, and on spectrophotometry. This limited the ability of the laboratory to isolate and identify drugs. Today, the high separating efficiency of thin-layer and gas-liquid chromatography can be used to isolate, unmodified by the methods, the drugs and/or their metabolic products, in reasonably pure form. Identification can also be carried out colorimetrically or spectrophotometrically. Recently, a very sensitive radioimmunoassay method for morphine has been developed.

There are a few relatively simple qualitative "screening" tests for drugs that are practical for emergency room use. Phenothiazines can be detected in urine by ferric chloride-perchloric acid-nitric acid mixture. Salicylates can be screened for with ferric chloride in urine. This reagent will also react with acetoacetic acid. This interfering acid can be eliminated by boiling the urine. This test for salicylates can also be used if percodan is suspected as this drug leads to large excretions of salicylates.

Most definitive drug tests use some form of chromatography for separation of the drug(s) from other body chemicals. The separated drug(s) can then be determined by ultra-violet spectrophotometry of varying pHs. The results are highly reliable and sensitive (0.1 mg/dl of blood sample). However, drug interactions can obscure a particular ultra-violet spectra and confuse the determination (salicylates, dilantin, and diuretics in the case of barbiturates). Because of this interaction and because the laboratory can not be expected to determine the many drugs available for abuse, the physician

must help the laboratory by indicating what drug(s) he suspects.

Because the therapeutic and toxic blood levels of some drugs are close, quantitative detection methods must have a high degree of sensitivity and accuracy. For example, a critique on barbiturates by the Commission on Continuing Education Council on Clinical Chemistry of the American Society of Clinical Pathologists states that whatever technique is used for identification of a particular drug, it should be "at least sensitive to detect therapeutic concentrations of the several barbiturates and have sufficient selectivity to make a reasonable identification."

This is dramatically illustrated by the case of phenobarbital. A blood concentration of 0.5 to 1.5 mg/dl is mildly sedative; the same concentration of a fast-acting barbiturate (amobarbital, secobarbital) can be fatal. Similar problems arise in the nonbarbiturate sedatives (ethchlorvynol-placidyl, gluetethimide-doriden, etc). Since these determinations have important therapeutic and even legal consequences, standards of performances in analytical toxicology are "currently under intensive criticism and investigation," (ASCP).

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PREHOSPITAL EMERGENCY CARE OF THE HEART ATTACK PATIENT

J E STOLFI MD

Emergency medical care of patients with a coronary heart attack is divided into prehospital and inhospital phases. Inhospital treatment made excellent progress during the last decade, with the development of coronary care units. Prehospital treatment has lagged behind.

Mobile emergency rooms and coronary care vehicles deliver medical care to patients quicker and more efficiently. Equipped with monitors, shock equipment, and drugs they allow trained personnel to treat patients on the spot and enroute to the hospital.

Nothing has been done to sustain life until a mobile unit arrives. Now an attempt is being made to provide that missing but essential link. The American College of Physicians has embarked on a mass educational program on cardiopulmonary resuscitation. This prestigious society, by using the expertise of 20,000 members, hopes to implement this lifesaving training program on a nationwide basis.

Cardiopulmonary resuscitation combines mouth-to-mouth respiration and closed-heart massage. The latter is accomplished by applying downward pressure on the breastbone with the palm of the hand. By squeezing it toward the backbone, the heart is compressed and blood is forced out into the general circulation. A sudden release of pressure causes the heart to suck blood back into its chambers. If repeated once a second and accompanied by blowing air into the lungs through the mouth (12 times a minute), life can be sustained for periods in excess of 30 minutes.

The knowledge gained in coronary care units, by monitoring patients for long periods, has shown that when the heart stops beating or is rendered inefficient by a rapid or irregular rhythm, it must be restored within four minutes to preserve the brain.

When cardiac arrest occurs in the street, restaurant, theater, sports stadium, golf course, or home, it is difficult to provide professional care within that critical period. The number of sudden deaths due to heart attacks annually is about 350,000. To save some of them we will have to teach, all old enough to understand, the simple but effective resuscitative procedure outlined here. By instructing a large number, help for those stricken may be at his side. Sustaining life until professional help arrives will save thousands of victims each year. The risks involved if the procedure is performed improperly include damage to ribs and bruised organs. Some people may not have a coronary. Subjecting them to resuscitative procedures will do no harm; potential for good greatly outweighs the risks involved.

The College of Physicians, in cooperation with the Heart Associations, will urge physicians to join in this national effort. Demonstrations on mannequins and movie films will be used to train the general public.

Autopsies have revealed that many people who die suddenly have no apparent heart damage. Death may have been caused by a reversible electrical disturbance in rhythm, known as fibrillation. If resuscitated, these individuals could live a normal life.

A side issue concerns legal action against those who perform the procedure improperly. Several states have enacted laws protecting individuals who perform emergency procedures. They should be adopted universally. This legal problem emphasizes the need for good instruction. Interest, cooperation, and participation by all members of the medical profession, as well as the general public, is necessary for the success of this vital drive for life.

Well-equipped mobile units staffed with trained personnel are now delivering medical care in a shorter response time to the patient

whose life is being sustained. The number is small but increasing. A cardiologist and nurse are best prepared to utilize the electrical defibrillators, monitors, rhythm-controlling medications, and pain-killing drugs. However, the shortages of both precludes their use.

To compensate for this, both cardiologists and anesthesiologists have, for many years, offered training programs in the specifics of treatment and ventilatory techniques. Residents, nurses, aides, attendants, and even drivers, can be trained to use or help in the application of the special equipment and drugs. Thump version, closed cardiac massage, and the use of oxygen, after establishing open air passages, are procedures done frequently by individuals trained to treat heart disease and administer anesthesia.

Using these techniques enroute to the hospital completes the life-sustaining chain. The hospital can be alerted by a two-way communication system and prepare to receive the patient. On arrival at the institution the heart attack victim is transferred from the vehicle to the intensive or coronary care unit without interrupting treatment. When in the special unit, the cardiologist and the anesthesiologist take over and institute treatment which has already been proven to reduce the percentage of deaths.

The foregoing depicts the ideal method of treating the individual whose collapse results from a coronary heart attack. It begins at the time of onset and continues through transportation and arrival at the hospital. This is designated as prehospital care. The procedures that take place after arrival are classified as inhospital emergency care. Many articles are available in medical journals that describes the latter in detail and need not be repeated here.

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Scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians and medical institutions who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held at the Baltimore Civic Center on

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Ample space is available; however, it is suggested that applications be submitted as soon as possible.

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Fill in and mail to: Chairman, Exhibit Subcommittee
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1. Title of exhibit:
2. Please attach a 50-100 word description of the exhibit:
3. Give amount of space required, depth, width, and height:
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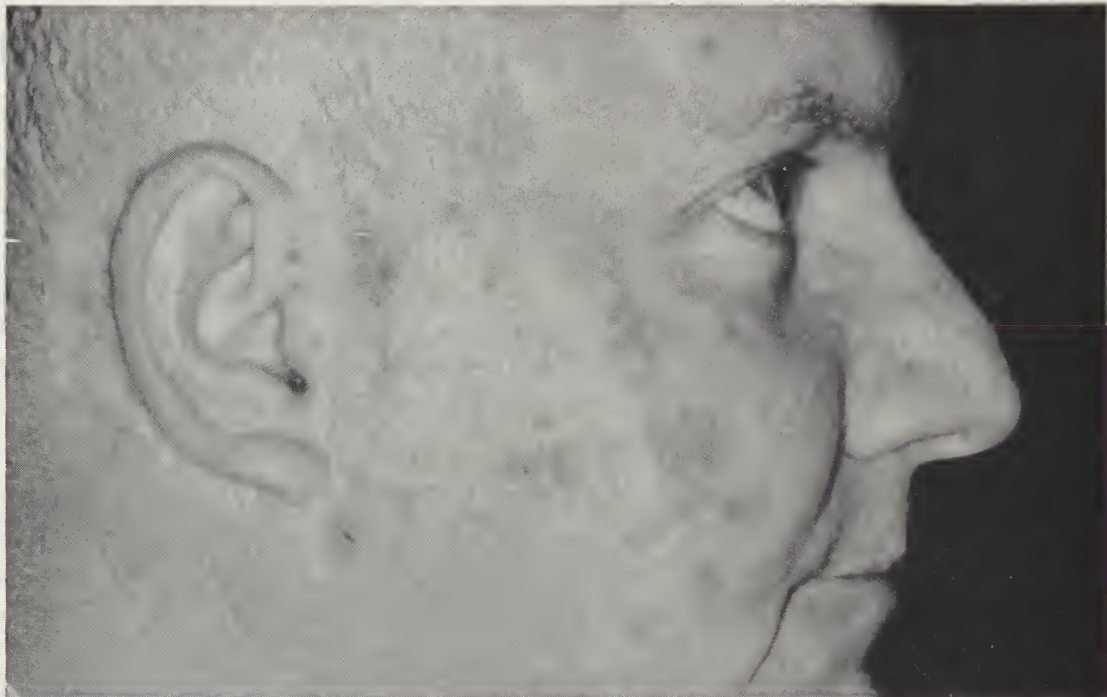
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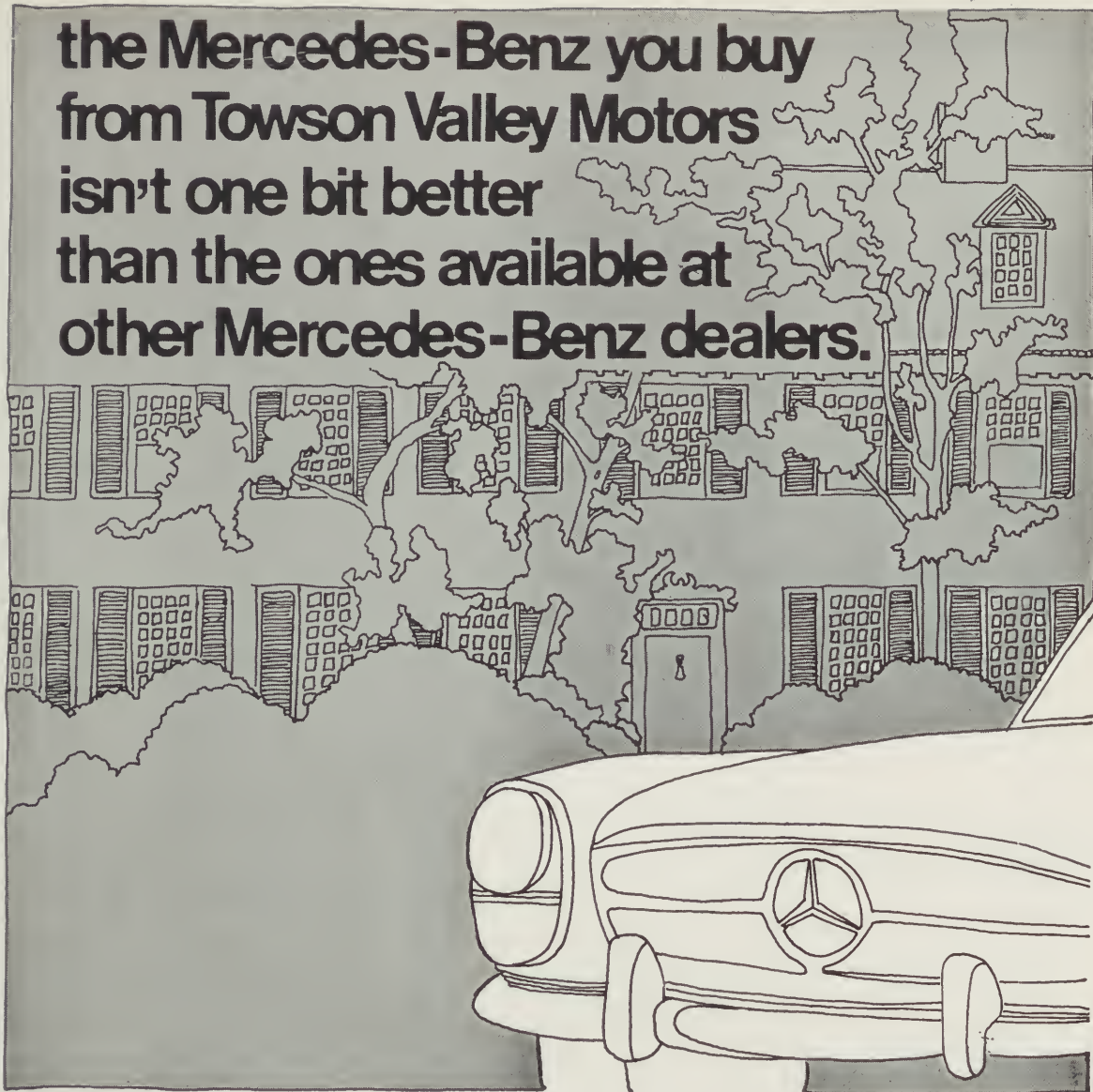


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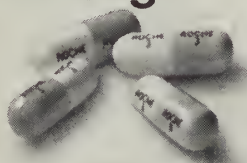
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

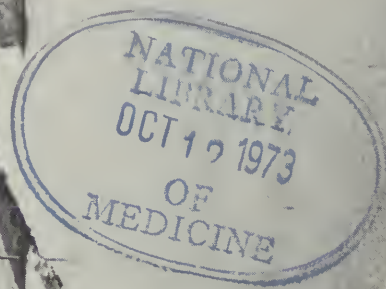
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug

should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they occur, are secondary to increased rates of basal metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

It has been shown that *Synthroid* (T₄) converts to T₃ at the cellular level to supply metabolic needs.^{1, 2}

1 *Synthroid* is T₄.

2 Because T₄ converts to T₃ at the cellular level, it provides full thyroid replacement at maintenance doses.^{1, 2}

3 T₄ hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

5 *Synthroid* provides predictable results when used with current thyroid function tests.

6 *Synthroid* is the most prescribed brand name of thyroid in the U.S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

8 When stored properly, *Synthroid* has a longer shelf life than desiccated thyroids.

9 On a daily basis, *Synthroid* is cost competitive with other thyroid products.

The smooth road to thyroid replacement therapy.

Synthroid[®]
(sodium levothyroxine)

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain of desiccated thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is gained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, the initial dose should be 0.025 mg. daily. The

dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T₄) to Triiodothyronine (T₃) in Athyreotic Human Subjects, J. Clin. Invest. 49:855-64, 1970.

2. Surks, M. I., Schadow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. 51:3104-13, 1972.



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In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

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Tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-300-F (10/71)

For complete details, including dosage, please see full prescribing information.

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More than sleep.

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is wisely based on more than
sleep-inducing potential

sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hours
without need to
repeat dosage

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

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onsistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage. Dalmane (flurazepam HCl) is a distinctive sleep medication—a zodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, non-barbiturate agent proved effective and relatively safe for relief of insomnia.

DALMANE[®]

(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule h.s. — usual adult dosage
(15 mg may suffice in some patients).

One 15-mg capsule h.s. — initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage. 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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"Prescription drugs – who should determine the maker?"

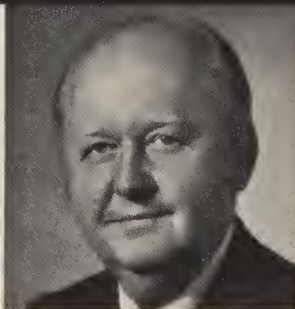
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"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MDs have given the impression they are not particularly concerned with the increase in cost of health care to the patients . . .

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 2%

ould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health

30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with that particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substitution pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that the courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advo-

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



ROCHE announces new

BACTRIMTM

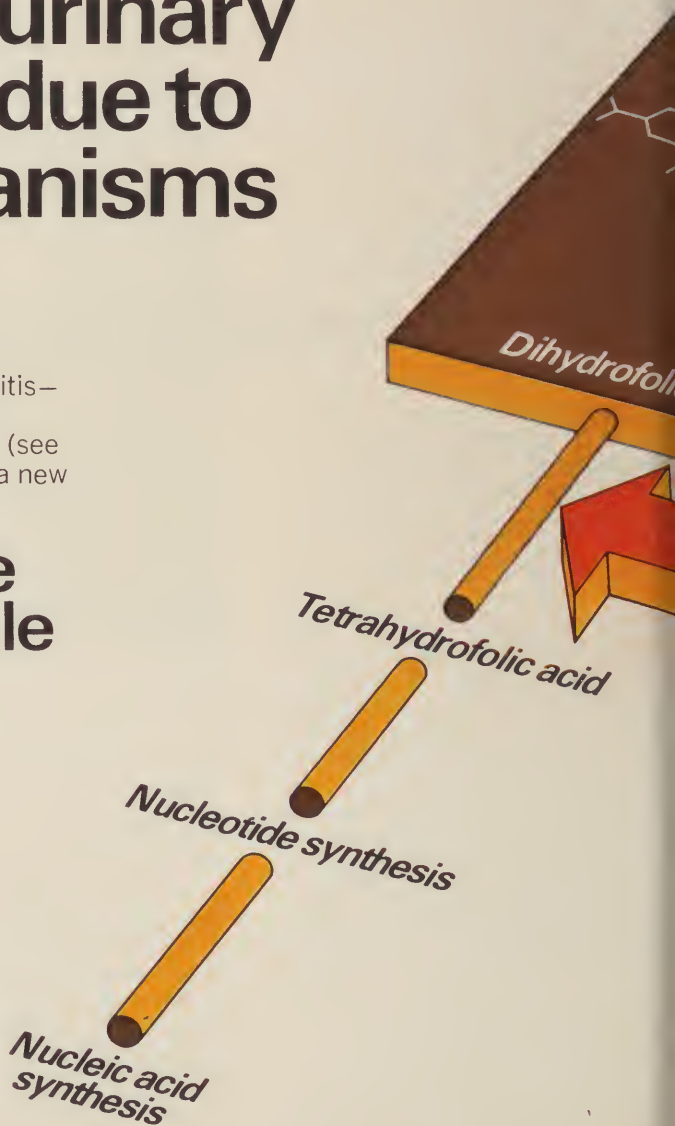
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

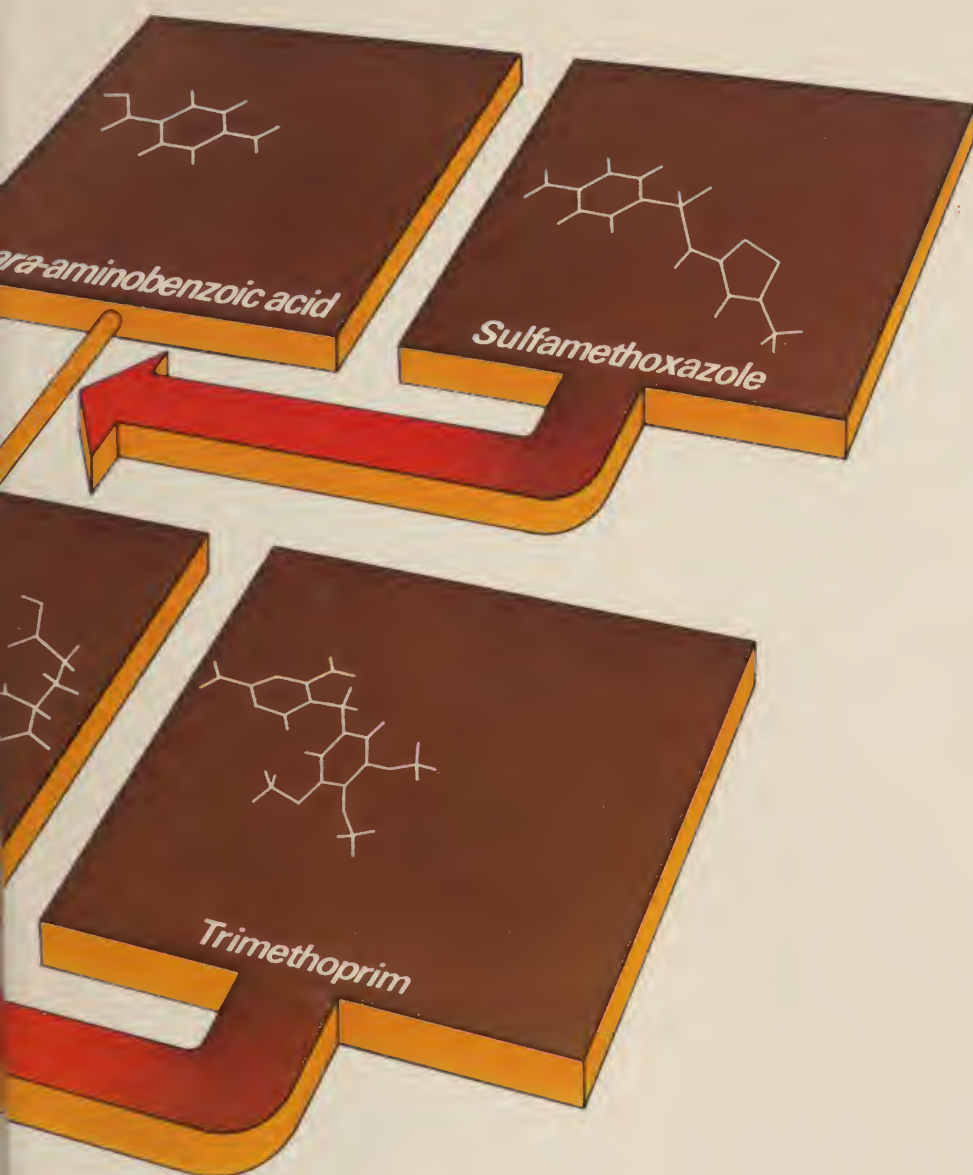
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





new **BACTRIM**^{T.M.}

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.
for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471[†] patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

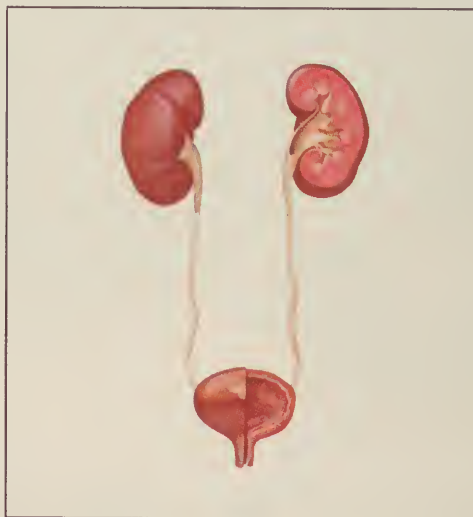
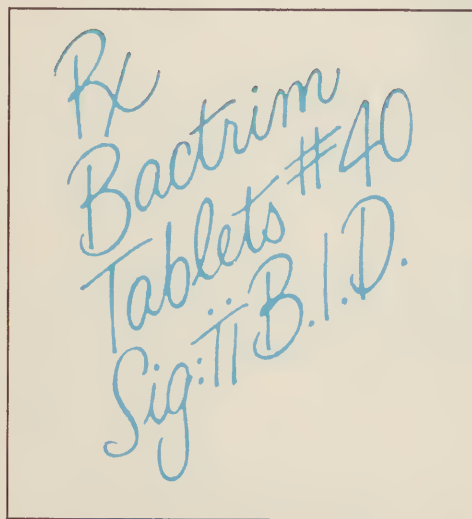
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

[†]4 patients not available for evaluation at day 10.



new **BACTRIM**TM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N¹-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: Microbiology: Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20)	
			TMP	SMX
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp.	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Indole positive <i>Proteus mirabilis</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Klebsiella-Enterobacter</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim/sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma increases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than in the concentrations in the blood. When administered together in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Important note: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIMTM
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and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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To help you manage excessive psychic tension

ETHICS CORNER

Recently the Physician/Patient Relations Committee considered the question of payment for services rendered by house officers in institutions. There has been a long-standing ruling by the Council to the effect that a private physician must be personally present when these services are rendered, in order to bill either the patient or a third party for care.

Some physicians are under the impression that a telephone conversation with a House Officer constitutes the basis for submission of a bill for total services to the patient or third party.

The Physician/Patient Relations Committee has again considered this matter at some length and again confirms that a physician may bill only for those services actually rendered by himself, or for services rendered by a house officer under his personal supervision, and only when he is physically present.

It is ethical for a physician to bill for follow-up services such as return office visits, X-rays, or other services rendered in the private physician's office. It is not ethical for him to bill for services rendered by house staff, after consultation on the telephone and approval of any procedure carried out by the house officer.

Legal counsel has advised that legal responsibility for giving instructions to the house officer does not constitute a basis for billing for the services rendered by that house officer. Such legal responsibility is a responsibility accepted as part of teaching duties and hospital admitting privileges.

All physicians are, again, reminded of their responsibilities in connection with billing for such services.

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- Oct 7 to Mar 3 ***Horizon Center Seminar Series**, 7 seminars, limited to 24 mental hlth professionals. Contact: Dr L J Gallant, Horizon Center Inc, Suite 614, 1101 N Calvert St, Baltimore Md 21201, (301) 539-8175, 20 hrs cr
- Oct 13 & 20 **Drug Use & Abuse**, 1st anl symposium, Med-Chi Bldg, 1211 Cathedral St, Baltimore. Sponsor & info: Balto City Med Soc, 1211 Cathedral St, Baltimore Md 21201, phone 539-4628. No regis fee. 4 hrs AAFP cr ea session
- Nov 7 **Medical Society of DC**, symposium, Can Hodgkin' Disease Be Cured? Contact: Medical Society of the Dist of Columbia, 2007 Eye St NW, Washington DC 20006
- Nov 27 ***Acute Respiratory Failure: Causes, Monitoring & Mgt**, Holy Cross Hosp, Silver Spring, 1-4 PM. Sponsor: Med Advisory Comm of TB&RD Assoc of Frederick, Howard & Montgomery counties. Contact: Mrs Margaret Besman, 170 Rollins Ave, Rockville Md 20852, (301) 881-6852, 3 hrs cr
- Dec 1 ***Bicentennial Geriatrics Symposium**, Baltimore City Hospitals, 9 AM-4 PM. Contact: Dr E G Beacham, Baltimore City Hospitals, 4940 Eastern Ave, Baltimore Md 21224, (301) 342-5400 ext 647, 6 hrs cr

AMERICAN COLLEGE OF PHYSICIANS

(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104.)

- Oct 29-Nov 2 **Clinical Rheumatology: Diagnosis & Treatment of Arthritis & Related Diseases**, Univ of Arizona Col of Med, Tucson
- Oct 29-Nov 2 **Decision Making in Internal Medicine**, Med Col of Georgia, Augusta
- Nov 2-4 **Mgt of Critically Ill Patient**, Univ of Southern California Sch of Med, Los Angeles
- Nov 12-14 **Pulmonary Disease: Clinical, Immunological & Pathological Correlations**, Mayo Clinic, Rochester Minn
- Nov 12-15 **Advances in Clinical Cancer**, Univ of California, San Francisco
- Nov 14-16 **Hypertension: Current Trends**, Cornell Med Cen, New York Hosp, New York City
- Nov 28-30 **Human Hypersensitivity Disorders: Clinical Aspects & Pathogenic Mechanisms**, Univ of Michigan Med Cen, Ann Arbor

MISCELLANEOUS MEETINGS

- Oct 25-27 **Amer Col of Gastroenterology**, anl crs in postgrad gastroenterology, following anl conv Oct 22-24, Biltmore Hotel, Los Angeles. Contact: ACG, 299 Broadway, New York NY 10007
- Oct 29-Nov 1 **Interstate Postgrad Med Assoc**, 58th anl scientific assembly, Palmer House, Chicago. Designed for family physicians & internists. Contact: Program Chmn, Interstate Postgraduate Med Assoc, PO Box 5445, Madison Wisc 53705
- Oct 26-27 **Postgrad Crs in Otolaryngology for Family Physicians**, Playboy Plaza Hotel, Miami Beach. Contact Div of Continuing Educ, Univ of Miami Sch of Med, PO Box 875, Biscayne Annex, Miami Fla 33152

- Oct 26-28 **AMA Speakers & Leadership Programs**, Marriott Motor Hotel, O'Hare Airport, Chicago.
Nov 16-18 Contact: AMA Speakers & Leadership Programs, 535 N Dearborn St, Chicago ILL 60610
- Nov 2-4 **Amer Col of Radiology**, seminar on skeletal system, St Louis. Contact: ACR, 20 N Wacker Dr, Chicago Ill 60606
- Nov 5-9 **Practical Mgt & Therapy of Neurologic Disorders**, an inservice dept of Neurology, Univ of Miami
- Nov 9-11 **Clinical Electromyography**, Eden Roc Hotel, Miami Beach. Info on this & preceding crs: Div of Continuing Educ, Univ of Miami Sch of Med, PO Box 875, Biscayne Annex, Miami Fla 33152
- Nov 9 **Trends in Diagnosis & Treatment of Tumors of Nervous System**, symposium. Contact: Dr H G Seydel, Dept of Radiation Therapy, Amer Oncologic Hosp, Central & Shelmire Aves, Philadelphia Pa 19111
- Nov 8-10 **Radiologic & Other Biophysical Methods in Tumor Diagnosis**, 18th clinical conf, Shamrock Hilton, Houston. Contact: Dr G P Dodd, Anderson Hosp, Univ of Texas Med Cen, Houston Tex 77025
- Nov 5-9 **Neuroradiology**, trng prog, New York City. Contact: Office of Recorder, Med Science Bldg, New York Univ Med Cen, 550 First Ave, New York NY 10016
- Nov 8-10 **Society for Computer Med**, 3rd natl conf, Denver. Contact: Dr J M Edelman, Society for Computer Med, 200 Professional Cen, 244 Peachtree Blvd, Baton Rouge La 70806
- Nov 10-15 **Amer Assoc Blood Banks**, 26th anl mtg, Americana Hotel, Bal Harbour Fla. Contact: AABB, 1828 L St NW, Washington DC 20036
- Nov 11-14 **Southern Med Assoc**, 67th anl mtg, Convention Cen, San Antonio. Contact: Southern Med Assoc, 2601 Highland Ave S, Birmingham Ala 35205
- Nov 6-9 **Amer Soc of Cytology**, 21st anl scientific mtg, Salt Palace, Salt Lake City. Contact: Dr W R Lang, Amer Soc of Cytology, 7112 Lincoln Dr, Philadelphia Pa 19119
- Nov 11 **Office Mgt of Infertile Couple**, San Antonio. Contact: Registrar, Amer Fertility Society, 1801 Ninth Ave S, Birmingham Ala 35205
- Nov 16-17 **Diagnostic Laparoscopy**, Flushing NY. Contact: Dept of Ob-Gyn, Booth Memorial Med Cen, Main St at Booth Memorial Ave, Flushing NY 11355
- Nov 29-Dec 1 **Recent Advances in Ob-Gyn**, New York City. Contact: Ob-Gyn Society of New York Med Col, 1249 Fifth Ave, New York NY 10029
- Nov 23-24 **Radiology in Otolaryngology & Ophthalmology**, conf, Chicago. Contact: Prof Valvassori, Radiology Dept, Abraham Lincoln Sch of Med, PO Box 6998, Chicago Ill 60680
- Nov 29-Dec 1 **Virology & Immunology in Human Cancer**, natl conf, Waldorf-Astoria Hotel, New York City. Contact: Dr S L Arje, Natl Conf on Virology & Immunology in Human Cancer, American Cancer Society, 219 E 42nd St, New York NY 10017
- Nov 29-Dec 2 **Amer Assoc for Clinical Immunology & Allergy**, anl mtd. Hilton Palacio Del Rio, San Antonio. Contact: Dr R J Brennan, Amer Assoc for Clinical Immunology & Allergy, 3471 N Federal Hwy, Ft Lauderdale Fla 33306



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woman's auxiliary

ARE WE GOING FORWARD TOGETHER?

When the AMA meets, what do they discuss? A reading of the 1973 Highlights of the AMA Convention reveals 18 hours, 51 minutes of meetings with 263 items of business and a wide range of issues affecting medicine.

Every year, the President's inaugural address sets the direction for the year. As I read this year's address, one glaring omission stood out. There was no indication that the AMA would use its most valuable resource. What is that? The Woman's Auxiliary! No mention was made of the Auxiliary even though the tone of the address was a plea for support to cope with the critical problems facing medicine.

In sharp contrast, the Woman's Auxiliary, at the same meeting but in separate quarters, was being told by Harry Schwartz PhD, member of the Editorial Board of the *New York Times* and author of *The Case for American Medicine*: "The doctor's wife can be a great service to the doctor in improving the public image of American medicine. Get to know the facts; most doctors are too busy to know the facts; this is where you can help. Good American medicine is something you all should cherish and try to defend."

The Auxiliary, in trying to be more effective, amended its bylaws to read: "The purpose of the AMA Auxiliary is to assist the American Medical

Association in its program to improve the quality of life through health education and services."

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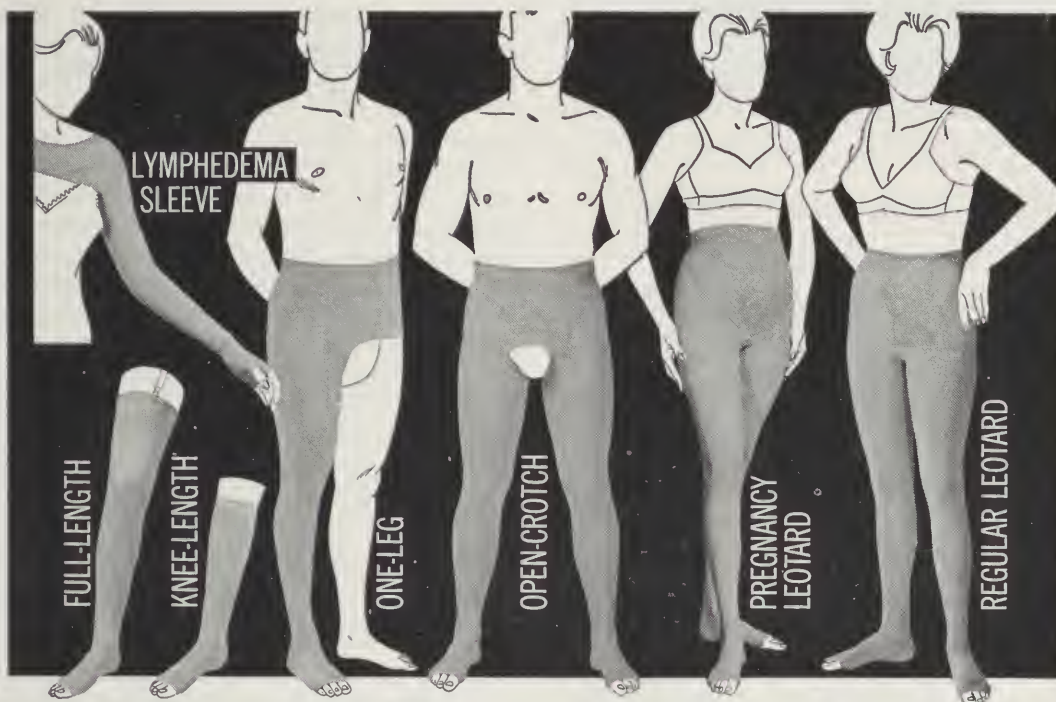
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the lung page

A Service of the American Lung Association of
Maryland and the Maryland Thoracic Society



Editors:

G DOUGLAS CARROLL JR MD
MICHAEL G HAYES MD
C RODNEY LAYTON JR MD
EDWARD RUSCHE MD

American Lung Association: Shorter Name, Wider Aim

The American Lung Association has been one of the most successful of the American voluntary health associations. The change in its name at the present time recognizes the fact that tuberculosis is now on the decline due largely to the development of new drugs, but also in all probability associated with improved living standards. This definitely does not mean that tuberculosis is licked, but the outlook is hopeful.

Lung cancer, pulmonary emphysema, diseases of medical progress (infections associated with steroid and antineoplastic treatment), and diseases of industrial progress (diseases associated with cigarette smoking and air pollution) are rising in importance and need attention. These are the tasks of the American Lung Association, and it approaches them in a strong and enthusiastic position. It is a hopeful task, for much of the work is of a preventive nature.

American Lung Association

In 1882, Robert Koch proved that tuberculosis was caused by a bacillus. It was not until ten years later that a remarkably persistent and vigorous Philadelphia physician, Lawrence F Flick, formed the Pennsylvania Society for the Prevention of Tuberculosis, the first American association of lay and medical persons devoted to the conquest of a specific disease. In 1894, Flick recommended reporting of all cases of tuberculosis. In response to this, the College of Physicians of Philadelphia stated that it "believes that the attempt to register consumptives and to treat them as subjects of contagious disease would be adding hardships to the lives of these unfortunates, stamping them as outcasts of society; the College respectively requests that no official action be taken by the Board of Health."

It was an uphill fight, but by 1904 Flick had organized what was later called the National Association for the Study and Prevention of Tuberculosis. In that year there were 8,000 beds for tuberculosis patients in the United States. By 1911, there were 26,000 and 89,690 by 1938, most of them paid for by public organizations.

In 1916, the town of Framingham Mass was selected by the National Tuberculosis Association (the first name change by the National Association for the Study and Prevention of Tuberculosis) for a study under a grant from the Metropolitan Life Insurance Company. This first important public study of tuberculosis demonstrated that seven times as many cases of active tuberculosis existed in the town as had been known to practitioners or the public health authorities. Infant health clinics were started; milk was pasteurized; the sick were taken care of. In six years, the infant death rate fell by 35% and the tuberculosis rate dropped 68%. On this experience, the National Tuberculosis Association built its program of case-finding, adequate treatment and better hygiene. In 1968, the National Tuberculosis Association changed its name to the National Tuberculosis and Respiratory Diseases Association. Finally, in this year of 1973, the new official name of the organization is the American Lung Association.

In 1905, the American Trudeau Society was founded as the professional branch of the National Association for the Study of Prevention of Tuberculosis. In 1960, it changed its name to the American Thoracic Society. It has been particularly interested in the publication of the American Review of Tuberculosis which changed its name to the American Review of Respiratory Diseases.

It has also put on yearly professional conventions at which the latest information in research, teaching, and treatment is disseminated to the profession. The national organization supports a fellowship and research program.

Maryland and Tuberculosis

A number of distinguished physicians have been associated with the tuberculosis movement in Maryland.

Dr Gordon Wilson, later Professor of Medicine at the University of Maryland School of Medicine, established the first separate ward for patients with tuberculosis in a general hospital. With the decline in the need for hospitalization, the idea of caring for open tuberculosis cases in a general hospital had a renewal. Dr

Wilson continued to care for the tuberculosis patients at Bayview for a number of years.

Dr Henry Jacobs was the first Secretary of the National and first President of the Maryland Association for the Prevention and Relief of Tuberculosis. The Christmas Seal agency was established Dec 13, 1904. In 1919, the organization became known as the Maryland Tuberculosis Association. In 1969, it changed its name to the Maryland Tuberculosis and Respiratory Disease Association; and in May 1973, its present name, American Lung Association of Maryland, was adopted.

Dr G Canby Robinson was another distinguished physician who contributed significantly to the Maryland TB Association. After having spent a career in founding or rejuvenating medical schools at St Louis, Nashville, New York City, and Peking, he returned to Baltimore, where he participated, particularly in the teaching of medical students at Johns Hopkins, and served as Executive Secretary of what was the Maryland Tuberculosis Association from 1946 to 1955.

The medical arm of the Association, the Maryland Thoracic Society, was organized in 1959 and became a Chapter of the American Thoracic Society in 1972. Society membership totals 195.

Many other physicians and lay alike have contributed their energy, time, and money to the Maryland TB Association. Although tuberculosis is still a major problem in the US, it appears that it can now be approached by Health Departments with expectation that it can be greatly reduced in incidence over the next decade. The need for expensive hospital beds for long periods of time is reduced.

Thus, the American Lung Association of Maryland can look forward to attacking the relatively new diseases of lung cancer, obstructive lung disease, diseases of industrial progress, and diseases of medical progress.

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McCREADY MEMORIAL HOSPITAL

McCready Memorial Hospital, the only hospital in Somerset County, was established in 1923 as a memorial to Mr Edward W McCready, a native of Crisfield who had become a successful businessman in Chicago.

On a visit to his Crisfield home in 1919, a tragic auto-train accident occurred at a nearby railroad crossing which took the life of Mr McCready, his daughter, and her nurse-maid.

The efforts and care of the staff of the old Marine Hospital in Crisfield, and of the community in general, so impressed the surviving Mrs McCready that she desired to recompense the hospital staff and the town and did so by providing funds to establish a new hospital in the community in memory of her husband and daughter.

McCready Hospital, with 36 general acute beds, is situated just outside the city limits of Crisfield on a beautiful site overlooking the little Annessex River. The original structure remained relatively unchanged until 1961 when a new wing housing a modern Operating Room, Labor and Delivery Room, and six-bed Obstetrical Unit was completed.

Approximately seven years later, a modern 64-bed extended care facility was added. The facility was named the Alice Byrd Tawes Nursing Home after the mother of former Maryland Governor J Millard Tawes who resides in Crisfield and currently serves as a member of the Board of Directors of the organization.

The Hospital and Nursing Home program is geared to meet the general acute and long-term health care needs of lower Somerset and Worcester county residents. Its present active medical staff complement of seven physicians includes three general practitioners, a general surgeon, an Ob-Gyn specialist, a radiologist, and an ENT specialist.

James A Sterling MD presently serves as Chief of Staff, with Elbert Detwiler as Administrator.

It has long been known that many of those parents who abuse their children were themselves abused and neglected. Could the friendship of a motherly type help such parents break the abuse syndrome? St Luke's Hospital in New York City recently announced it would try to find out in a new program.



FRANCIS C MAYLE MD
Chairman

MRS FRANCIS C MAYLE
Editor

MMPAC NEWS ITEMS

As this is being written in early August before a vacation deadline, the ultimate outcome of the Watergate hearings is still very much in doubt. A few words may nevertheless be said concerning Watergate and the American Medical Political Action Committee. AMPAC, it should be remembered, is a nonpartisan organization which never involves itself in presidential elections. Here in Maryland, as all over the country, all AMPAC campaign contributions are carefully reported in full compliance with the laws. AMPAC membership is up 6% over last year with an increasing interest in Sustaining Membership. In Maryland, we are quite proud of our membership achievement this year and are working hard to achieve even more. These facts surely show continued confidence in the importance and vitality of AMPAC.

We are looking forward to a stimulating year in MMPAC. Since this is an off-election year, we have time to devote our attention to other matters.

Membership is, as always, our first priority. All MMPAC members should be responsible for recruiting new members from among their acquaintances. Sustaining Membership is a very important tool which many members can consider. Complacency is a fatal disease.

There are three MMPAC committees devoted to our constant membership drive. The first is the Regular Membership Committee, the second is the Sustaining Membership Committee devoted especially to increasing the number of our sustaining members, and, finally, there is the Membership Retention Committee which works to be sure that all past members rejoin each year.

Plans are underway to enlarge the MMPAC Board to achieve greater membership participation. We also hope to increase the cooperation between MMPAC, the Faculty, and the Wom-

an's Auxiliary. The members of the Auxiliary can be an invaluable tool of the PAC organization, particularly in the area of Candidate Support Committees.

A MMPAC Workshop, designed to be an educational opportunity for all MMPAC members, is planned for later in the year. You will hear more details later, of course, but we encourage all MMPAC members to participate so they will be better able to direct PAC efforts in their local areas. AMPAC headquarters will assist in the preparation of a stimulating program. Such a learning experience should lead to active Candidate Support Committees in the next election.

All MMPAC members will soon receive a survey questionnaire to answer. We urge them to consider their replies carefully, since the results will be used by the MMPAC Board as a guide for future planning.

The Chairman and other members of the MMPAC Board are always available to speak at meetings or provide other types of programs. Do not hesitate to ask for their assistance.

An active membership is an effective membership. We urge all MMPAC members to volunteer to participate in some way in the work of the PAC. Contact your District Chairman for any information you need.

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Compounded and
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Credited Quarterly
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Yield: 6.92

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executive director's newsletter

October 1973

PUBLIC SPEAKING SEMINAR

An all-day public speaking program is set for Thursday, Nov 1, 1973, at the Faculty building. Enrollment is limited. This yearly session is well worth the \$10 enrollment fee which includes lunch.

For further information, telephone the Faculty office; or send your check to cover cost of registration.

MEDICARE FORM CHANGE

All references to "reasonable charge" have been removed from the Medicare Explanation of Benefit forms. In addition, the column caption designating the amount upon which benefit payment is based now uses the term "amount approved" instead of "allowable charge."

TRIENNIAL REREGISTRATION FORMS

Triennial Registration forms are somewhat delayed in being mailed out to physicians. Physicians whose surnames begin with the letters H-M are being processed alphabetically; those whose surnames begin with initials N-Z will be notified in 1974.

CONTINUING MEDICAL EDUCATION

Full details on Maryland's requirement for continuing medical education were mailed to all physicians holding Maryland licenses during September 1973.

If further information or details are desired, contact should be made with the Board of Medical Examiners, (301) 383-2020, 1211 Cathedral St, Baltimore Md 21201.

PRACTICE MANAGEMENT SESSIONS

A two-day workshop on Establishing Yourself in Medical Practice has been set for Thursday and Friday, Dec 13 and 14, 1973, at the Faculty building.

Presented in cooperation with the American Medical Association, the session is conducted by professional consultants who can answer specific questions and is limited to 25 physician registrants so that instructors are able to discuss individual problems.

Full details can be obtained by contacting the Faculty office or responding to the individual mailing being sent all Faculty members.

1974

TRAVEL PLANS

Travel plans for 1974 have currently been established as follows:

Jan 11, 1974, 14-day trip to Australia, New Zealand, and Tahiti

May 5, 1974, 15-day trip to Athens (7 days) and an 8-day trip of Greek Islands including Istanbul

Late September/early October, trip to Oktoberfest, Munich, Germany (date to be made available) (7 days)

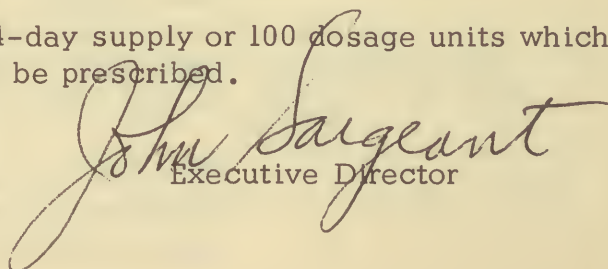
REGULATIONS ON PRESCRIBING OF AMPHETAMINES AND METHAMPHETAMINES

Physicians are reminded that restrictions have been placed on the prescribing of all amphetamines and methamphetamines. In general, these restrictions permit the use of these drugs under the following circumstances only:

- 1) Narcolepsy - patient shall be clearly diagnosed by physician as such and must be stated on patient record.
- 2) Hyperkinesis - patient shall be clearly diagnosed by physician as such and must be stated on patient record.
- 3) In exceptional cases of obesity - adequately documented, both initially and as to continuing need. Physicians must notify the Division of Drug Control, Department of Health and Mental Hygiene in writing within ten days of initial prescription. The Division of Drug Control will refer those cases that should be further reviewed to the Faculty. Simple obesity does not call for the routine use of amphetamines to attain weight reduction.
- 4) In selected rare cases not listed. In each case the physician must be able to justify and document medical need by adequate records and notify the Division of Drug Control, Department of Health and Mental Hygiene within ten days of the initial prescription. The Division will refer those cases to the Faculty that should be further reviewed.

The prescribing and dispensing of parenteral amphetamines or methamphetamines is prohibited.

No more than a 34-day supply or 100 dosage units whichever is less shall be prescribed.


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Bureau of Preschool Health Services**

DIAGNOSIS AND TREATMENT OF CHILDHOOD LEAD POISONING

I. **Diagnosis of Lead Poisoning:** The following protocol for evaluation of lead poisoning is recommended:*

Blood Lead Level	Clinical Picture	Diagnosis	Follow-up and Treatment
40-49 mcgs% (2 determinations)	Asymptomatic	Undue Absorption of Lead	No medical treatment; environmental correction; repeat screen in near future; screen other young children in dwelling
50-79 mcgs% (2 determinations)	Asymptomatic, and no other evidence of lead poisoning**	Undue Absorption of Lead	As above
	Asymptomatic, and other evidence of lead poisoning	Lead Poisoning	Report to Health Department; ambulatory or hospital treatment; environmental correction; repeat screening after treatment; screen other young children in dwelling
	Symptomatic, and other evidence of lead poisoning	Lead Poisoning	Report to Health Department; hospital treatment; environmental correction; repeat screening after treatment; screen other young children in dwelling
80-and above mcgs% (2 determinations)	Asymptomatic or symptomatic with or without other evidence of lead poisoning	Unequivocal Lead Poisoning	Report to Health Department; hospital treatment; environmental correction; repeat screening after treatment; screen other young children in dwelling

II. **Treatment for Lead Poisoning**

Ambulatory treatment: Calcium EDTA (Versene), 50 mgs/kg/day in two daily intramuscular doses. 1.5 cc of 2% Xylocaine may be mixed with drug immediately prior to injection. This combination should be injected daily for five days unless the patient manifests symptoms of drug toxicity.

Hospital treatment: For children with high blood lead levels (50 or higher mcgs%) but without signs of encephalopathy, oral penicillamine may be administered. When signs of encephalopathy are present, treatment should be with Calcium EDTA and BAL.***

III. **Additional Information**

For additional information concerning diagnosis and treatment of lead poisoning, you may call the Bureau of Preschool Health Services, 396-4463.

For laboratory supplies and assistance in the determination of blood lead levels, you may call the Bureau of Laboratories, 396-3733.

*Surgeon General's Statement on Childhood Lead Poisoning, Public Health Service, Department of Health, Education, and Welfare, 1970

**These may include positive lead lines in long bones, basophilic stippling of red cells, elevated protoporphyrin in blood, etc

***The Medical Letter on Drugs and Therapeutics, Vol 14, No 3, Feb 4, 1972



ROBERT E FARBER MD MPH
Commissioner

Baltimore City health department

Lead Poisoning Tests

A free nonappointment clinic to test youngsters for lead paint poisoning utilizing fingertip blood and a modification of the Delves Cup Micro Atomic Absorption Method is now open Mondays from 1:00 PM to 3:00 PM in the Druid Health District Bldg, 1515 W North Ave. This, the City Health Department's first "walk-in" lead clinic, requires no advance appointment. The new clinic is for those children who otherwise do not have access to lead poisoning screening. Children who attend a regular child health clinic, comprehensive children, and youth clinic or hospital pediatric clinic may get screening from their regular source of care.

The City Health Department invites physicians to take advantage of the new fingerstick testing clinic and refer their child patients who may be at risk. Some criteria for children of high risk are:

- 1) The child is between one and six years old.
- 2) The child has been seen eating paint, plaster or other nonfood items.
- 3) The child is generally irritable, fussy, with vague abdominal pain.
- 4) The family lives in an old house with peeling paint and plaster.

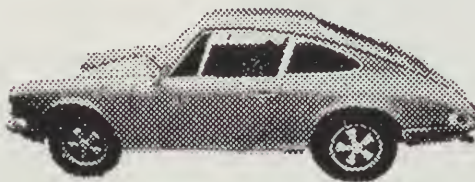
Baltimore's lead paint poisoning program was recently enlarged with funds from the US Department of Health, Education, and Welfare. Early in the year, the City Health Department began testing on a routine basis all youngsters attending selected child health clinics serving the inner city areas. The new "walk-in" clinic represents the second phase of the project which, it is hoped, will eventually provide a lead poisoning check for all susceptible children in the city. To date in 1973, 30 children have been diagnosed with clinical lead poisoning. An addi-

tional 354 children had abnormal amounts of lead in their blood but no apparent physical symptoms.

Since the families of suspect children are visited by Health Department personnel, physicians may request assistance in checking on either patients or home conditions by calling Mr William R Smith, Administrative Health Officer and coordinator for the Department's Child Lead Poisoning Project, at 396-4427.



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Doctors in the News

John M Buchness MD has been appointed Deputy State Health Officer for Somerset, Wicomico, and Worcester counties.

He fills the vacancy created by the death of Dr William C Fritz in February.

Dr Buchness formerly served as Regional Health Director of the US Public Health Service in Denver, retiring from the Public Health Service in 1971 after serving since 1956.

He was educated at Loyola College of Baltimore and received his MD from the University of Maryland Medical School in 1948.

Raymond Seltser MD, Associate Dean of the Johns Hopkins University School of Hygiene and Public Health, has been chosen by the Boston University School of Medicine as one of its outstanding graduates of the last half century.

Dr Seltser was cited for his achievements in understanding risk factors involved in radiation injury, stroke, and cigarette smoking.

He received his MD from Boston in 1947 and his MPH from their School of Public Health in 1957.

The American College of Physicians has announced that a total of 315 physicians in the US and Canada have been made Fellows of the 57-year-old international society which represents specialists in internal medicine and related fields.

All MDs, the new Maryland Fellows include:

Clara J Fleischer and Kent E Robinson, Baltimore

From Bethesda: Richard A Binder, Paul W Brown, David W Shea Jr, Richard J Sherins, and CDR Lawrence W Raymond MC USN

Leonard P Appel and Norman K Bohrer, Bowie

George Lawrence, Columbia

John H Hornbaker Jr, Hagerstown

Major Phillip P Toskes USA, Rockville

John Alan Singer MD, of the Department of Surgery at the University of Maryland School of Medicine, has been awarded a research project grant by Southern Medical Association.

The grant will help to fund Dr Singer's project: The Production of Fever by Blood in the Gastrointestinal Tract, the Peritoneal Cavity and the Retroperitoneal Space.

Randolph M Howes MD, of the Department of Surgery at the Johns Hopkins University School of Medicine, has been awarded a research project grant by Southern Medical Association.

The grant will help to fund Dr Howe's project: Studies to Determine the Possible Role of Electronic Excitation States in Wound Healing.

James G Zimmerly MD JD MPH, member of the Howard County Medical Society, has recently joined the new *Journal of Legal Medicine* as a member of the Editorial Board and as a Contributing Editor.

He writes the bimonthly column entitled "The Washington Scene" for this publication, the official Journal of the American College of Legal Medicine. Dr Zimmerly has also had several articles published in the *Maryland State Medical Journal*.

Three Maryland MDs, members of the ASA, have recently been certified as Fellows of the American College of Anesthesiologists:

John Joseph Conroy, Arnold

Howard Emory Hudson Jr, Fort Meade

Kou-Chen Yu, Bethesda



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Raymond M Yow MD, Salisbury, has been elected President, Mid-Atlantic Section, American Urological Association.

Dr Yow is in his second year as Chief of Staff, Peninsula General Hospital, Salisbury.

•
Timothy J Tehan MD, Bethesda, has been elected to the Board of Trustees of the Suburban Hospital Association Inc.

•
Paul Burgan MD, Baltimore, has been named Associate Chief of Pediatrics at Baltimore's Sinai Hospital. He was formerly Assistant Pediatrician-in-Chief.

In assuming his new role, Dr Burgan will continue in several other capacities including Sinai's genetics counseling program.

•
The John F Kennedy Institute for the Habilitation of the Mentally and Physically Handicapped Child has announced the appointment of **Robert B Johnston MD** to the newly created position of Coordinator of Training.

•
Dr Johnston will be concerned with improving the quality of interdisciplinary training in over 16 departments at the Institute and broadening the involvement of each student in Kennedy's total facilities.

Dr Johnston received his MD from Georgetown University School of Medicine in 1964 and came to the Institute in 1971 as a Fellow in Pediatric Neurology, the position he held until his current appointment.

•
Robert M Blizzard MD,

Acting Chairman of the Department of Pediatrics at the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, recently received the Ayerst Award of the Endocrine Society of the US.

The annual award cited Dr Blizzard for his contributions made on a national and international level to the endocrinology field.

Dr Blizzard was a prime mover in making it possible to conduct research on human growth hormone and other human pituitary hormones on a national scale.

He was also an organizer and cofounder of Human Growth Inc, a lay organization which supports and sustains the nationwide collection of human pituitaries and research on human growth.

Dr Blizzard is Eudowood Professor of Pediatrics at the Hopkins and has been on the faculty since 1960.

Last year, he was awarded the Alumnus Merit Award from Northwestern University for outstanding achievement and leadership in the health and science fields.

•
C Alex Alexander MD, of the faculty of the University of Maryland School of Medicine, is leading a five-man team of health professionals in Niger Africa, studying the health care needs of the Lake Chad region, a famine area.

The school is lending Dr Alexander, an Associate Professor in Social and Preventive Medicine, to the sponsoring organization, Africare, a nonprofit group in Washington, which promotes health, education, and welfare projects in Africa.

Four physicians, new to Dorchester County, recently met the press in a luncheon-conference hosted by the Dorchester General Hospital, Cambridge Md.

They are **Patrick T McLoughlin**, a GP; **Vasilios D Korovilas**, Ob-Gyn; **Mohammad A Toor** and **Mahamood B Shariff**, Internists and Cardiologists.

It was noted that this is the first time in many years that so many new doctors have come to Cambridge at one time.

•
Barbara Williams Hudson MD has been appointed Medical Director at Rosewood State Hospital.

The New York native is a graduate of Columbia University College of Physicians and Surgeons.

She has been an Assistant Professor of Pediatrics at the University of Maryland Hospital; a Pediatric Consultant in the William S Baer School for Handicapped Children in Baltimore City; and Assistant Director of the Central Evaluation Clinic for Children at the University of Maryland Hospital.

•
The following Marylanders, all MDs, were recently certified as Diplomates of the American Board of Anesthesiology:

Brian F Condon, Wheaton

Nemesio G Cuevo, Bethesda

Brian G McAlary, Bethesda

Frank E Mack, Gaithersburg

Nelson A Villamor, Columbia

Albert I Mendeloff MD, Professor of Medicine at the Johns Hopkins University School of Medicine, and Physician-in-Chief at Sinai Hospital (Baltimore), has been elected President of the American Gastroenterological Association.

The Association is the oldest medical specialty group in the US. Dr Mendeloff has been head of its research committee, and advanced through the offices of Vice President and President-elect.

The native of Charleston WV attended Princeton and Harvard. He has been on the faculties of Boston University, Washington University (St Louis), and the Hopkins.

He was President of the American Federation for Clinical Research in 1958-1959.

The American Gastroenterological Association offers programs in undergraduate and postgraduate education in gastroenterology. The membership includes internists, surgeons, physiologists, and biochemists.

Eugene B Brody MD has assumed the post of Associate Dean for Social and Behavioral Studies at the University of Maryland School of Medicine.

Dr Brody formerly served as Chairman of the Department of Psychiatry and Director of the Institute of Psychiatry and Human Behavior.

During the year Dr Brody, in this new position, is investigating the need for a Department of Social and Behavioral Studies, **Russell R Monroe MD** will replace him.

In a related move, **Stanford B Freidman MD** has been appointed Professor of Psychia-

try and Human Development and Director of the Division of Child and Adolescent Services in the Department of Psychiatry.

The Memorial Hospital at Easton Board of Directors announces two new department chiefs.

John I F Knud-Hansen MD has been named Chief of Surgery. **David T Harper MD** was appointed Chief of Medicine.

Other department heads, all MDs, who were reelected include: **Alfred A Leszczynski**, Anesthesia; **Ronald C Lenthall**, General Practice; **Justin T Callahan**, Ob-Gyn; **E C H Schmidt**, Pathology; **Ali Mehrizi**, Pediatrics; and **Willard Machle Jr**, Radiology.

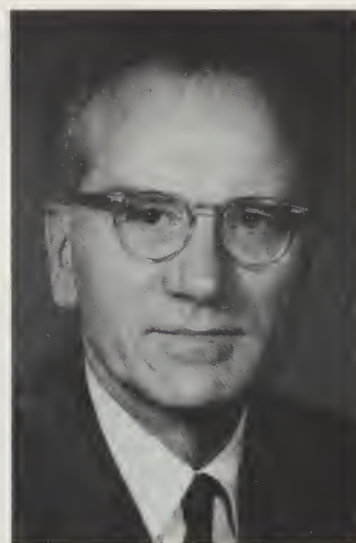
Spencer Foreman MD has been appointed Executive Vice President of Sinai Hospital of Baltimore.

Dr Foreman was Director of the US Public Health Service Hospital in Baltimore.

In accepting the Sinai post, Dr Foreman will resign his commission, the equivalent of a naval captain with the Public Health Service, and end his affiliation as a consultant in pulmonary diseases with three Baltimore hospitals.

A native of Philadelphia, Dr Foreman is a graduate of Ursinus College and received his MD from the University of Pennsylvania.

He came to Baltimore in 1967 when he was appointed Assistant Chief of Medicine for Pulmonary Diseases at the USPHS Hospital. He rose through the hospital's administrative ranks and was appointed Director last year.



Dr McKusick

Victor A McKusick MD has been appointed as the chairman, Department of Medicine, Johns Hopkins University School of Medicine, and Acting Physician-in-Chief at the Johns Hopkins Hospital.

Dr McKusick, formerly Professor of Medicine, takes over the duties of **A McGehee Harvey MD**, according to **Russell H Morgan MD**, Dean of the School of Medicine.

Dr Harvey had asked to be relieved of his responsibilities so that he could devote his time to writing, to the international programs of the school, and to research in rheumatology.

Dr McKusick began his professional career in cardiology; in recent years his basic work has been in cataloging and defining genetic disorders and genetic factors in disease.

Dr McKusick is a 1964 graduate of the Johns Hopkins University School of Medicine and completed his internship and residency training at the Johns Hopkins Hospital.

He joined the faculty in 1947 and has served as Chief of the Division of Medical Genetics for 16 years.

Medical Miscellany

Clinical Center Studies

The cooperation of physicians is requested in the referral of patients for two studies being conducted by the National Institute of Child Health and Human Development's Reproduction Research at the Clinical Center, National Institutes of Health, Bethesda Md.

Patients with either untreated ACROMEGALY, or treated but still active acromegaly, are being sought for a trial with medical therapy.

Patients with HIRSUTISM and/or VIRILIZATION are being sought for endocrine evaluation and therapy.

Upon completion of studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission may write or call Dr D Lynn Loriaux, Clinical Center, Room 10B-09, NIH, Bethesda Md 20014, (301) 496-5800 or 496-4686.

Blindness Research Grants

The National Society for the Prevention of Blindness announces that it has research funds available for pilot projects which do not exceed \$5,000 per year. Investigators not currently financed by other sources of research funds are invited to apply.

Acceptable projects are those which may contribute to the prevention of blindness and eye disease through basic studies of eye function and disease, or that may improve diagnosis and treatment.

Grants are made for a one-year period. The maximum period of support for research is two years.

The National Society for the Prevention of Blindness will accept applications any time during the year and will make awards promptly after evaluation by their Committee on Basic and Clinical Research.

Application forms and further information may be obtained by writing to the Committee on Basic and Clinical Research, National Society for the Prevention of Blindness Inc, 79 Madison Ave, New York NY 10016.

Postdoctoral Students Aided

The Johns Hopkins University School of Medicine has received a \$450,000 grant from the Andrew W Mellon Foundation for the support of young postdoctoral students.

The grant, to be used in the next two to three years, will provide fellowships to young scientists who are pursuing careers in teaching and research in the basic medical sciences.

In acknowledging receipt of the Mellon grant, Dr Russell H Morgan, Dean of the Medical School, said:

"Without the financial support for continued education and the opportunity to conduct independent research, many of our most promising young scientists would be forced to turn to other careers. In a time of uncertain government support, we are most grateful to the Mellon Foundation for their recognition and support of this vital educational program."

Radioactive Study Grant

The Johns Hopkins University School of Medicine has received a \$579,107 grant from USDHEW to study the safety and effectiveness of radioactive materials in medical practice and biomedical research.

Such studies are increasingly important because of the rise in the use of radioactive substances in this field, according to Dr Henry N Wagner Jr, Director of the Division of Nuclear Medicine.

The three-year grant will be used to continue critical examination of existing medical applications of radioactive material and to develop new applications.

VD On Increase

The AMA Council on Environmental, Occupational, and Public Health reports that venereal diseases continue to increase.

Gonorrhea ranks first and syphilis third among the reportable diseases in the US, excluding influenza.

As VD is both a medical and social problem, physicians have an important role in bringing the present epidemic under control.

The Council has prepared a Statement on Venereal Disease for the information and guidance of physicians.

Copies may be secured from the Faculty office or from the Council, 535 N Dearborn St, Chicago Ill 60610.

Clinical Center Study

The cooperation of physicians is requested in the referral of patients with multiple basal cell carcinomas for therapeutic trials being conducted by the National Cancer Institute's Dermatology Branch at the Clinical Center, NIH, Bethesda Md.

Of interest are patients with 12 or more basal cell carcinomas, including patients with the basal cell nevus syndrome.

Physicians interested in having their patients considered for admission to these studies may call collect or write to Dr W R Levis, Clinical Center, Room 10N-254, National Institutes of Health, Bethesda Md 20014, (301) 496-2481.

Manfred S Guttmacher Award

The American Psychiatric Association invites applications for its Manfred S Guttmacher Award for 1974. The award is given for any outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper or any other work, including audio/visual presentations (films, etc) submitted to or presented at any professional meeting or published during the year ending Dec 31, 1973.

The award, an honorarium of \$250 and a plaque, will be presented at the Convocation of Fellows at the annual meeting in May 1974 in Detroit.

Anyone who wishes may apply to receive the award by submitting five copies of the work as well as five abstracts to Dr Jonas Rapoport, Chairman, Guttmacher Award Board, 1700 18th St NW, Washington, DC 20009. Deadline for submissions is Jan 1, 1974.

Immune Deficiency Diseases

The cooperation of physicians is requested in the referral of patients with ataxia-telangiectasia for a study being conducted by the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda Md.

Ataxia-telangiectasia is characterized by cutaneous and conjunctival telangiectasia, cerebellar ataxia, and recurrent respiratory infections.

A full and prompt report of all studies done, as well as recommendations for therapy, will be sent to referring physicians.

Physicians interested in having their patients considered may write or call Dr Warren Strober, National Cancer Institute, Bldg 10, Room 4N114, Bethesda Md 20014, (301) 496-6781.

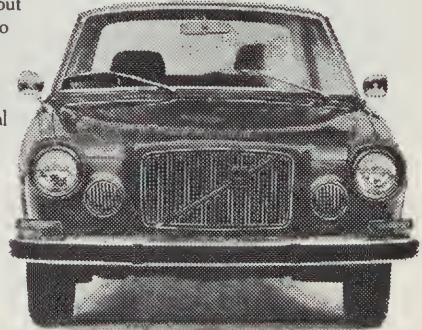
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Journal Representative

Baltimore City Medical Society

Board of Directors Acts

May, June, and July were exceptionally busy months for the Board of Directors and the officers of the Baltimore City Medical Society. Along with regular monthly meetings of the Board, there were several meetings with chiefs of medical staffs of Metropolitan Baltimore's hospitals and a meeting with representatives from Baltimore City on the Med-Chi Council. Subjects which required the greatest amount of interest and activity: Maryland Admissions Review Program (MARP); formation of Professional Standards Review Organization (PSRO) Regions; Peer Review activities, and location of the BCMS office.

The Maryland Admission Review Program (MARP), administered by the Maryland Foundation for Health Care, became operational on June 1 in some Baltimore hospitals. MARP provides for preadmission review of elective admissions of medical assistance patients. The program will be expanded to include all hospitals in the State within the next few months. Representatives of the Foundation have met with the Board of Directors and the hospital staffs to explain the administrative procedures involved in the implementation of MARP.

During the month of August, a meeting was held with representatives of the Department of Health, Education and Welfare and officers of the state and local medical societies in Maryland to discuss the formation of Professional Standards Review Organization (PSRO) Regions. Various aspects of this subject have been discussed by the Board during the past several months. On June 12 the following motion was passed by the Board of Directors:

"The Baltimore City Medical Society Board of Directors approves the formation of a Professional Standards Review Organization centered in Baltimore. The President (is) directed to write the officers of the counties included in the

Standard Statistical Metropolitan Area informing them of the action of the Board of Directors and indicating that this does not preclude their participation in a Baltimore Metropolitan Standards Review Organization if they so desire."

Representatives of the Society will attend the meeting with members of HEW to present the views of the Board of Directors and to ensure that the voice of the Baltimore City Medical Society's membership is heard.

Activities of the Peer Review Committee will become even more important with the advent of PSRO. The Board has discussed the actions of the Peer Review Committee on a number of occasions. Of considerable concern is the fact that cases referred for review by some major insurance companies are first sent to the Med-Chi Peer Review Committee which may either retain them or forward them to the component society for review. It is the opinion of the BCMS Peer Review Committee, and that of the Board, that all Baltimore City physicians should be reviewed by the BCMS Peer Review Committee. To this end, the following motion was passed at the May 15 meeting of the Board:

"When an insurance agency wishes to refer a physician for peer review, a letter should be sent to the office of the Medical and Chirurgical Faculty stating the physician's name and asking where the complaint should be referred. The Medical and Chirurgical Faculty staff should ascertain the physician's locale and medical society affiliation and inform the insurance company of the name of the appropriate component society."

This was referred to the Medical and Chirurgical Faculty Council but no definitive action has yet been taken.

For the past year, there has been much concern over the obvious need for additional office

space of the Society's headquarters. Since Med-Chi's Annual Meeting, the Med-Chi Ad Hoc Building Committee has been in contact with the appropriate officials in the City of Baltimore to the Society's present needs and those in the land next to the Faculty building. It is expected that a report will be made at the Semiannual Meeting of the House of Delegates. Before that time, the Policy and Planning Committee of the BCMS will present its recommendations as to investigating possibility of purchasing in the foreseeable future. The possibility of joining with Med-Chi in a condominium type arrangement is being carefully considered.

Among other activities, the Board has

- requested the Membership Committee and the Bylaws Committee to review the membership sections of the Bylaws to make the interpretation of the membership categories more definitive and to investigate the possibility of accepting house staff as active members at a reduced membership fee.

- approved the request of the Committee on High School Athletics to present a program on football injuries to the coaches of high schools in Baltimore City and to recruit physicians, through the Society Newsletter, to perform physical examinations on the students and to attend high school football games in the fall. The Committee was also asked to investigate the possibility of forming a multi-phasic screening program for the students which could be carried out mainly by paramedical personnel. It was felt that this would provide better medical screening while conserving the time needed by physician for examination.

- reviewed and accepted with appreciation several reports of the activities of the Project Review Committee of the Regional Medical Program submitted by Dr Rachel Gundry.

- approved the recommendation that the Society's Annual Meeting on December 6 be held in conjunction with an Oyster Roast at Martin's West.

- endorsed immunization regulations as requested by the Med-Chi Subcommittee on Immunization Practices.

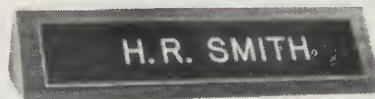
- allocated funds for the Executive Secretary to attend a PSRO Conference in Washington DC on August 10 and 11.

- directed that a letter be sent to the Superintendent of Public Instruction enclosing a copy of the AMA's letter of concern about the program "What Price Health" produced and distributed by NBC-TV and informing him that speakers on the subject are available from the Society's Speakers' Bureau.

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John Galsworthy

FREDERICK J BALSAM MD
Editor

rehabilitation medicine

BASIC ASPECTS OF REHABILITATION MEDICINE IN CHRONIC ARTHRITIS

LEWIS J GOLDFINE MD

Dr Goldfine is Associate Professor, Department of Rehabilitation Medicine, University of Maryland School of Medicine, Baltimore Md 21201.

The use of physical methods in the management of chronic rheumatic disorders in general is only part of the medical care of the patient; to be effective these measures should be an adjunct to the optimum medical treatment.

Physical therapy does not cure arthritis. However, it is a predictable means of avoiding deformities and inhibiting and preventing muscle wasting, which are common in arthritis.

Regular daily care at home, with the help of a written home program, is more valuable than the occasional treatment at a hospital clinic, although both may be advantageously combined.

Rest and Activity

The amount of rest will vary for each patient. Complete bed rest is ordered when there is generalized joint involvement or severe systemic reaction. It is continued until there is a remission or improvement and partial bed rest may then be continued.

Bed rest does not necessarily provide adequate joint rest; movement in bed can result in stress on inflamed joints; hence the need to splint such joints to immobilize them. Inflammation also subsides with effective splinting, which is protective as well as therapeutic.

Bed positioning is important. The mattress should be firm and a bed board ($\frac{1}{2}$ to $\frac{3}{4}$ in plywood) should be used. Pillows should not be placed under the knees. Twice daily, the patient should lie on his abdomen with hips and knees straight and feet over the edge of the mattress, arms stretched alongside the head.

Too much rest, of course, with no exercise may result in a patient ending up with very little pain but contractures of all joints. An extreme example would be the patient who has

spent most of his time sitting in a chair; eventually his body would become shaped to that sitting position. On the other hand, too much exercise may result in continuing generalized joint pain and muscle aching but preservation of joint mobility.

Heat and Exercise

Removal of the load of weight-bearing and functional use from inflamed joints often leads to rapid diminution of pain, but local application of heat is often valuable at this stage, particularly as a preliminary to some form of exercise.

If arthritis is generalized, the hot tub bath or underwater exercises in a bath tub or "Hubbard tank" are very effective. Body weight is almost completely neutralized when floating in water.

The patient with very acutely inflamed joints seems to obtain most relief from hot moist packs over the affected joint, usually as a preliminary to exercise, for about 20 to 30 minutes three or four times a day.

Warm paraffin applications are especially effective in arthritis of the hands, wrist, feet, and ankles. The temperature of the melted paraffin should range from 120 to 130 degrees F. This may be accomplished by using a mixture of paraffin and liquid petrolatum in a ratio of four to one.

The extremity is dipped into wax which is allowed to harden and this procedure is repeated eight to ten times. The wax-coated extremity is wrapped in a plastic cloth for 15 to 20 minutes. The paraffin is easily pulled off.

If a patient is comfortable at rest, no useful purpose is achieved by application of heat. Heat does no more than act as a muscle relaxant and analgesic locally and also causes some improvement in the local circulation. The use of short-wave diathermy and ultrasound in hip disease may be more efficacious because of the greater depth of penetration of these forms of heat.

Splinting and Prevention of Deformity

Resting splints, either plaster of paris or the newer plastics, designed to hold affected joints in the optimal functional position, are of the utmost importance.

Foot and Ankle

If there is a tendency for the foot to drop, it can be prevented by supporting the foot with a molded splint, the foot being held at a right angle to the leg. The splint may be removed for daily range of motion exercises.

The Hip

The patient lies on his abdomen for 30 minutes several times a day to prevent hip flexion. Adduction deformities may be prevented by the use of sand bags or pillows between the legs.

Wrist and Hand

The hand and wrist should be splinted during resting periods to prevent flexion and ulnar deviation deformities. The wrist is usually held in 15-20 degrees of extension. The splints can be made from the newer plastics or plaster of paris and molded to the volar aspects of the wrist and reaching as far as the finger tips. Molded working splints can be provided for patients with arthritis and these fitted to the wrist and hand but only extend as far as the metacarpophalangeal joints so that functional activity of the hand is made possible.

Knee

Posterior splints to prevent flexion deformity of the knee are used at rest or used in progressive degrees of extension to overcome an already present flexion deformity; this is known as progressive splinting.

Each joint should be put through its full passive range of motion at least once a day and ideally several times a day. It is extremely important that the extremes of motion be preserved as they are the first to be lost, and this program should be pursued to the limits of the patient's tolerance to pain. By passive range of motion is meant that the joint is put through its range of motion by a therapist or helper. Conversely, active range of motion occurs when a joint is put through the range of motion by the person himself.

In addition, strengthening exercises are recommended to strengthen muscle groups which have become weakened secondary to joint disease. Muscle can be strengthened only by contraction against applied resistance; and this is done in a progressive fashion, increasing the amount of resistance as this is tolerated by the particular muscle group; hence the term progressive resistive exercise. Rheumatoid arthri-

tis is a systemic disease and striated muscle often reveals, histologically, atrophy and focal inflammation. In addition, vasculitis has been demonstrated in a small percentage of cases. Hence it may be prudent to modify an exercise program. If a particular exercise program causes pain for more than 30 to 60 minutes following the exercises, it should be modified.

So, together with the measures of splinting and range of motion, a graduated exercise program should be instituted to preserve muscle strength progressing from passive (not performed by the patient but by a helper) to active assistive (partially self-performed and partially with the aid of a helper) and finally to resistive exercises (performed by the patient against resistance).

Management of Weightbearing Joints

Hip

It cannot be emphasized too much that the obese patient should lose weight. For every extra pound of body weight, the load on the hip is increased approximately three-fold. Special nonweight-bearing exercises can be carried out in leg slings or a hydrotherapy pool. The main objectives are to preserve range of motion and to prevent flexion and adduction deformities. Raising of the shoe, if there is shortening on the affected side, often makes walking more comfortable. If the difference is small, the short leg may be raised at the heel up to about a third of an inch, lowering the other heel by an equal amount. The most useful measure is to encourage the use of a cane in the hand opposite to the affected side; this eases the pain, reduces the load, and hence the wear on the affected side. In fact, during walking with the use of a cane, the pressure on the head of the affected femur can be reduced to a weight equal to that when standing on two legs.

Knee

The importance of keeping the quadriceps apparatus strong cannot be overemphasized as this is the main stabilizer at the knee, and walking on a knee with weak quadriceps can considerably increase the damage to that joint. Active resistive quadriceps exercises using a DeLorme boot (weighted shoe) or other means of weighting the leg may be necessary.

The Correct Shoe

The basic prescription is a straight last shoe which conforms to the natural shape of the foot. Women should avoid high or narrow heels. Shoes should have a low, wide heel. Pronation is a common problem for which a long counter (an extension of the heel counter) and

a Thomas heel are prescribed. The Thomas heel has a medial extension into the sole.

Depressed metatarsal heads with overlying callus formation is another common finding, almost always accompanied by pain on weight-bearing. A simple, effective shoe correction is the metatarsal bar which, when fixed properly on the sole just posterior to the metatarsal heads, relieves pressure on the sensitive areas.

When foot problems do not yield to commercially available devices, it may be necessary to order custom shoes made from plaster casts of the patient's feet. The Murray space shoe with soft leather uppers and cushiony rubber and cork soles is a source of great comfort for many patients with severe deformity of the foot from an arthritic condition.

Occupational Therapy Aids

Many objects which are handled in daily use, eg, kitchen utensils and cutlery, can be pro-

vided with built-up handles to enable the patient to obtain a firmer grip on these particular devices. Also, patients with limited joint range of motion in the shoulders and elbows may be helped by such long-handled devices as combs and shoe horns.

If these programs are adhered to and attention paid to the details, in the context of the total medical management, there is a distinct advantage to be gained from the point of view of maintaining or increasing the optimum functional activity of a patient with a chronic arthritic problem.

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Arthritis and Physical Medicine, ed Sidney Licht, 1969.

Addendum

Additional information and literature for the use of physicians and patients may be obtained from the local chapter of the Arthritis Foundation, 12 W 25th St, Baltimore Md 21218, (301) 366-0923.

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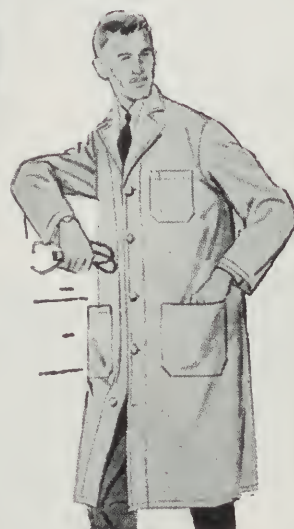
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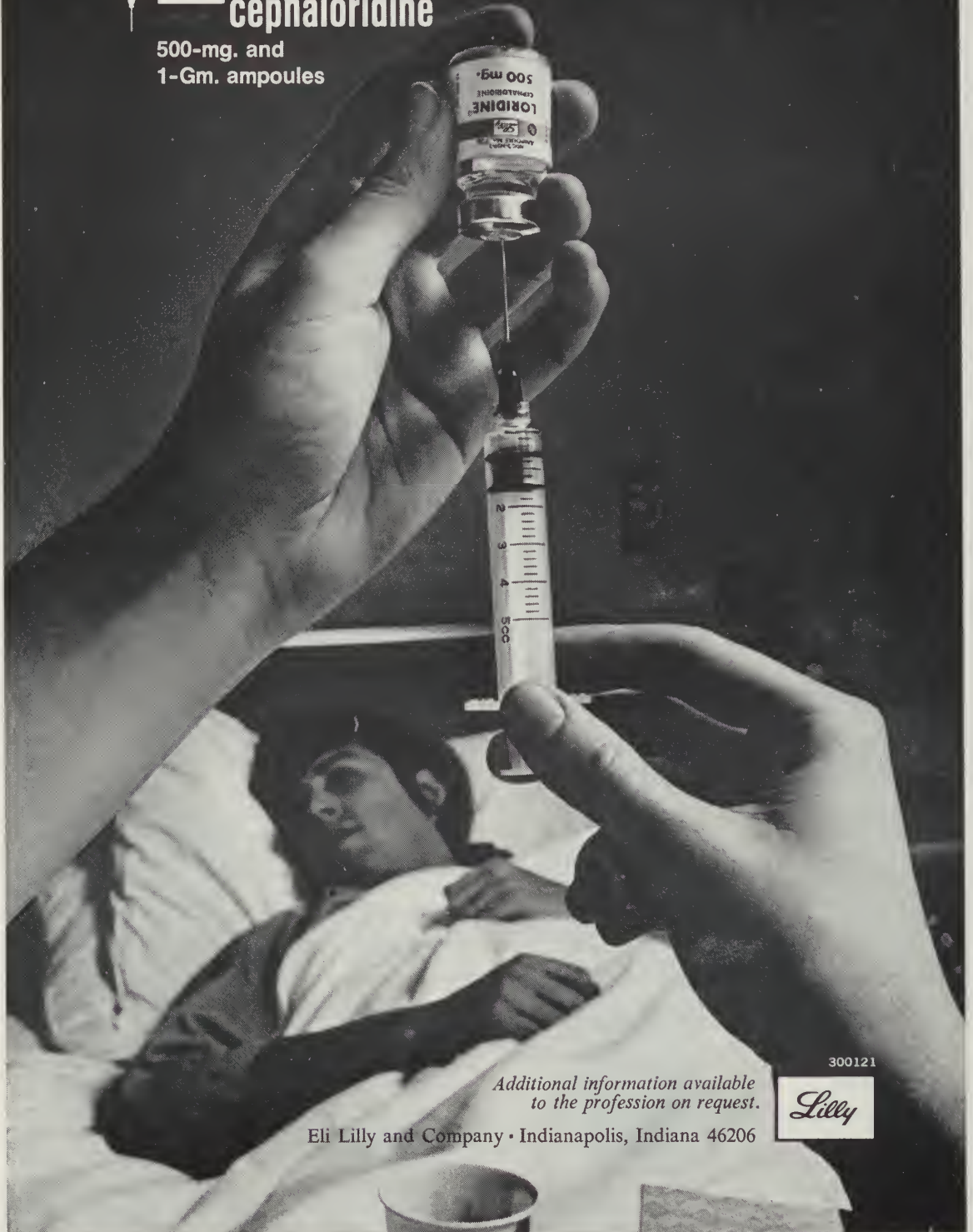
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Surgical Prevention and Correction of Deformities in the Rheumatoid Hand

GAYLORD L CLARK MD
E F SHAW WILGIS MD

Dr Clark is Assistant Professor, Orthopedic Surgery, Johns Hopkins University School of Medicine, Baltimore; also Attending Hand Surgeon, Union Memorial Hospital, Baltimore.

Dr Wilgis is an Instructor at the Johns Hopkins University School of Medicine; also Attending Hand Surgeon, Union Memorial Hospital.

Information and reprint requests to the authors at 5820 York Rd, Baltimore Md 21212.

Abstract

This article is an attempt to convey the present surgical thoughts about the treatment of the rheumatoid hand. The authors have emphasized the team approach to the problem. Both soft tissue and skeletal procedures are discussed in relation to the timing, the indications, and the expectations for this type of surgery.

Introduction

Since the last report in this Journal (pp 149-152, May 1967) by Gaylord Clark MD, the surgical treatment of the rheumatoid hand has undergone a gradual metamorphosis. Instead of proposing major reconstructive procedures to salvage badly deformed hands, the concept has evolved of early surgery before deformity occurs.

The target tissue of the disease process is the synovium, the lining of all joint cavities and the covering of tendons. In the rheumatoid process the synovium becomes locally destructive to tendons and joint surfaces by both its invasive and expansile nature. Because of the importance of this tissue, both the medical and surgical treatment is directed at its control or eradication.

The team approach to the treatment of the arthritic patient must be reinforced. The primary physician must be in charge when dealing with a chronic illness such as rheumatoid disease. The surgeon's role is to recommend and carry out treatment at various times in the course of the disease with the purpose of arresting the local process, preventing fixed deformities, or correcting established abnormalities. The treating physician and surgeon must work in concert to achieve optimum goals.

Indications for Surgery

Surgery on the rheumatoid hand can only begin at the physician's direction. The absolute indications are:

- 1) Imminent or manifest tendon rupture—either extensor or flexor
- 2) Imminent or manifest nerve compression
- 3) Troublesome nodule either in the tendon or subcutaneous tissue

- 4) Bone cyst in danger of fracture or collapse

The relative indications for surgery are:

- 1) Persistent synovial proliferation in the face of good medical therapy
- 2) Painful joints
- 3) Inconvenient joint stiffness
- 4) Faulty skeletal alignment
- 5) Diagnostic biopsy

It is to these relative indications for surgery that we address ourselves. We now believe that surgery applied to prevent deformities has a very definite and important role in the overall treatment.

Soft Tissue Surgery

This form of surgery relates to the treatment of tendons and joints without involving the bony structures. Synovectomy has been an important method of preventing tendon entrapment or rupture. The tenosynovium, when unresponsive to medical treatment, will invade tendons and cause attenuation with eventual rupture. For this reason, persistent, diseased synovial tissue surrounding the involved tendons must be removed. Dr Kauko Vainio of Heinola Finland has demonstrated that the incidence of tendon rupture in those patients who have had synovectomy is significantly less than in those left untreated. If a tendon does part, it can never be reconstructed to its absolute, normal state.

The extensor tendons over the dorsum of the wrist are most commonly involved and are predisposed to early damage because of their thin substance and isolated blood supply. These units are held in position over the dorsum of the wrist by a retinacular ligament beneath which all diseased tenosynovium should be removed. Nodules within the tendon substance must be carefully excised.

On the flexor surface of the hand, the tenosynovium surrounds all the tendons at the level of the carpal canal. Expanding synovium with-

in this region can cause median nerve dysfunction. Synovial expansion within the digital sheath restricts tendon excursion. Total removal of this tissue is imperative.

When a tendon has ruptured on the extensor surface of the hand, it can rarely be joined primarily. More commonly, an adjacent tendon unit must be used for a transfer to supply the motor power to the ruptured unit. The extensor surface of the hand lends itself reasonably well to this method. However, a parted flexor tendon within the finger must be treated by a free tendon graft. A flexor tendon disruption in the palm or carpal canal can be treated appropriately by a transfer utilizing an adjacent tendon unit.

Signs and symptoms of nerve compression, particularly of the median nerve in the carpal tunnel, are an indication for surgery. Release of the transverse carpal ligament combined with a total synovectomy of the flexor tendons will enable the patient to recover nerve function. Nerve compression left untreated will permanently damage this structure so that full motor and sensory recovery may not occur.

Joint synovectomy is readily carried out in the wrist, metacarpal phalangeal, and interphalangeal joint areas. It should be considered for relief of pain, and removal of persistent synovitis with the hope of protecting the supporting ligaments and joint surfaces from ongoing destruction.

A frequent cause of inconvenient interphalangeal joint stiffness is contracture or adherence of the intrinsic muscle tendon units within their gliding channels. This problem can be dealt with by an intrinsic release, or a tenolysis of the adherent segment to provide improved interphalangeal joint motion. In special circumstances, a combination of intrinsic release and joint capsulotomy will improve joint motion. The results are better if surgery is done before a fixed deformity occurs.

Skeletal Procedures

In this area of surgical treatment a number of alternatives exists and the appropriate method can be chosen to fit the problem.

The wrist is the key joint to the position and function of the hand, and alterations in its position and motion directly affect the hand as a unit. Available to us at the wrist are the following procedures: joint arthrodesis, arthroplasty, resection of the distal ulna with or without a silastic cap, and replacement of carpal bones with silastic implants.

The arthrodesis provides rigid stability with

stronger grip strength in the hand and freedom from pain. It is an irreversible operation and oftentimes difficult to achieve in the rheumatoid patient. The wrist arthroplasty does allow a degree of motion without pain and with stability. It is used most often in unstable wrists where there is volar subluxation of the carpus on the radius.

Ulnar head resection often relieves pain in the radial ulnar joint and allows improved wrist motion. Its replacement with a silastic cap, recently developed by Dr Alfred Swanson, has given surgeons a tool for improved reconstruction of the radial ulnar joint. It also prevents ulnar subluxation of the carpus and improves the cosmetic appearance.

Silastic replacement of carpal bones at the present is limited to the scaphoid, lunate, and trapezium. Of these, the most useful, in terms of rheumatoid surgery, is the trapezium (or greater multangular) in cases of arthritis in the thumb carpal metacarpal joint. It allows correction of thumb alignment with mobility, and stability where other procedures would be undesirable.

The metacarpal phalangeal joints are commonly involved in rheumatoid arthritis, and an understanding of the pathophysiology as well as the surgical treatment of these joints has undergone vast change in the past ten years. Synovectomy here, as already mentioned, still has its place in the prevention of deformity, however, once ulnar drift of the fingers is present or joint articular changes have occurred, or joint subluxation is evident, more radical surgery is necessary.

When these above abnormalities are present there is a concomitant decrease in the function of the hand. The two basic surgical approaches are 1) arthrodesis, and 2) arthroplasty by total joint excision. The arthrodesis will maintain finger alignment and increase the power of grasp distally; rigidity of this joint is undesirable in a multi-joint disease. If there is near normal interphalangeal joint motion, this method certainly offers improvement. Again, Dr Swanson has provided us with a valuable tool for the treatment of these joints. The silastic finger joint prosthesis allows for total joint excision and its replacement. This silastic spacer, with the proper soft tissue reconstruction, allows both stability and motion. Our collective experience now adds up to over 75 joints replaced in the hand. We feel that this approach is a vast improvement over any of the previously available methods.

Correction of deformities of the proximal in-

terphalangeal joints is possible by the same technique. The success of such procedures is highly dependent on the soft tissue reconstruction.

Deformities of the distal interphalangeal joint are only corrected by an arthrodesis. In many instances this operation has restored alignment and stability with improved appearance.

The thumb is frequently considered as a separate unit and may demand individual surgical attention. We have already mentioned the carpal metacarpal joint, but the metacarpal phalangeal and interphalangeal joint must also be considered. Several methods for tendon release and reattachment at the metacarpal phalangeal joint level are available for flexion deformities. Arthrodesis of this joint is quite successful provided there is good proximal and distal joint excursion. At the interphalangeal level, reconstruction of volar stability for hyperextension is possible by tendon transfer or by arthrodesis. Silastic spacers are occasionally used at the metacarpal phalangeal level but are not applicable in the interphalangeal joint. In their role at the metacarpal phalangeal joint, they may not provide enough stability for satisfactory pinch and grasp.

Surgical Contraindications

These are:

- 1) Lack of patient cooperation or motivation
- 2) Cardiovascular disease of sufficient degree to increase the surgical risk
- 3) Severe anemia

We do not consider the following to be surgical contraindications:

- 1) Active rheumatoid disease
- 2) Severe deformities even if well adapted
- 3) Steroid therapy
- 4) Hyper-cortisonism
- 5) Amyloidosis
- 6) Old age

The postoperative management of these patients is complex, intricate and time-consuming, yet an integral part of the surgical treatment. It basically follows a pattern of a period of immobilization, followed by protected mobilization utilizing various forms of splints—static, dynamic, and assistive. It is our belief that properly trained occupational and physical therapists can be of extraordinary value during this phase of treatment.

Expectations

Our surgical expectations are multiple:

- 1) To obtain tissue that will aid in the diagnosis

2) Prevention of deformity by arresting local disease

3) Correction of faulty skeletal alignment

4) Correction of nerve or tendon malfunction

5) Relief of pain

6) Intangible, but important, the emotional impact of preserving function and restoring a more normal appearance to a deformed hand

We recognize our limitations in dealing with this disease process. It is unrelenting and insidious in its destructive potential; however, if we can aid or improve in some way the patients ability to function normally in their society, we will try.

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THE PROBLEM OF CHILD ABUSE: A COMMUNITY HOSPITAL APPROACH

ROBERT S CHABON MD
GEOFFREY B BARNES MSW
LEONARD J HERTZBERG MD

Information and reprint requests to Dr Chabon, Associate Pediatrician-in-Chief, Sinai Hospital of Baltimore Inc, Belvedere at Greenspring Ave, Baltimore Md 21215.

Abstract

Sinai Hospital of Baltimore has formed a multidisciplinary team to deal with the problems of abused children and their families. This paper provides some historical and medical background of the problem of child abuse and details the approach of the team to dealing with abusing families. We describe the organization and function of the team and elaborate on plans for expansion of the program. We also describe our preliminary results and indicate future directions for evaluation.

Background

Over the past decade, medical and mental health practitioners have become increasingly conscious of the magnitude of selected social problems which tend to manifest themselves in destructive symptoms such as drug addiction, alcoholism, and the neglect and abuse of children. Specialized programs and projects designated to cope with the phenomenon of child abuse have arisen and are taking their place among a long list of historical antecedents.

Although child abuse is as old as recorded history, public and professional concern has increasingly begun to affect the direction and nature of dealing with this problem — perhaps indicative of the generalized response of a more mature and aware society. For many decades the responsibility for dealing with abused children and their families was vested in one or another public or private social welfare agency. These agencies have helped many troubled families in relative isolation from the mainstream of public life.

In a paper discussing the formation of centers for the study and care of abused and neglected children, Dr Ray E Helfer suggests that the development of such centers can only be justified if 1) they will provide a community with services that are not already in existence, and 2) one can demonstrate that currently there does exist a problem in providing comprehensive care to these children and their families.¹

Most large metropolitan communities have no

individual or coordinating agency to provide an interdisciplinary approach to the problem of child abuse. The disposition of such cases is often so poorly and incompletely resolved that the result, in extreme circumstances, is the death of the child. Practitioners in many fields find it difficult and distasteful to deal with abusing parents who in turn find themselves neglected and isolated at a time when they badly need assistance.²

Historical Aspects

Only within the past 15 years has there been an increasing medical awareness of a critical pediatric problem involving the neglect and abuse of children. In reality, this timeless problem has been hidden both medically and socially; in view of our obvious ignorance of the subject, it has also been hidden statistically. This appears to reflect society's unwillingness to accept the fact that inhuman cruelties could be willfully inflicted on children.

Historically, we can trace child abuse back through the centuries to ancient Greece and Rome where parents and teachers believed that the only cure for "the foolishness bound up in the heart of the child" was repression, especially by the use of the rod. It was assumed that the parents and guardians of children had every right to chastise their children in any manner they saw fit.³ Children in the United States, as well as in countries the world over, have always been subjected to a broad range of physical and nonphysical abuse by parents and other caretakers including teachers, child care personnel, and, indirectly, by society as a whole.

In the course of centuries progress has been made in protecting the interest and well-being of children, in comparison with earlier periods when parents tended to wield absolute power to the point of life or death over their offspring. Children were often abandoned to die of exposure, legally bartered and sold, mutilated to enhance their appeal as beggars, or thrashed by schoolmasters with rods or cat-o'-nine-tails.⁴ Extremes of mutilation such as castration, foot-binding, cranial deformation, and uvulectomy have been justified for cosmetic, religious, or social value; infanticide was often motivated by desire for population control in primitive populations, disdain for illegitimacy, greed for

profit in unscrupulous foster families, and as an aspect of ritual sacrifice. Abandonment of foundlings, especially in time of war or social upheaval, and the utilization of children to provide cheap labor during the Industrial Revolution are two further examples of societies' neglect and abuse of children.

Curiously, radiologists rather than pediatricians took the lead in identifying and attempting to describe the clinical picture of children subjected to child abuse. In 1946, Caffey made original observations regarding the association of subdural hematoma and abnormal X-ray changes in the long bones.⁵ A few years later Silverman reported similar findings and clearly identified the traumatic nature of the lesions.⁶ In 1955, Wooley observed that the trauma noted on the X-rays were in many cases willfully inflicted.⁷

In the early 1960s, Kempe was alarmed by the many children with nonaccidental injury admitted to his pediatric service. He contacted some 80 district attorneys in an effort to obtain a more accurate picture of the true incidence of the problem.⁸ In 1961, the American Academy of Pediatrics conducted a symposium on the problem of child abuse under the direction of Dr Kempe. To focus attention on the magnitude of the problem, he coined the term "battered child syndrome." This symposium sparked the present widespread interest in this problem.

Once roentgenologists and pediatricians had developed diagnostic procedures in suspected cases of child abuse, social workers in children's hospitals became concerned with the implications of this phenomenon for their practice. Elizabeth Elmer, at the Children's Hospital of Pittsburgh, noted the difficulties of professionals in maintaining an objective and helpful attitude toward parents who abuse their children; she felt society's repugnance for the phenomenon of child abuse contributed heavily to the reluctance of many physicians to accept the diagnostic impressions of radiologists.⁹

Legislation against child abuse dates back to the Code of Hammurabi. However, not until Kempe more clearly defined the dimensions of child abuse did major legislative revisions occur. In 1962, a Denver conclave of physicians, lawyers, and social workers formulated a model child abuse law; by mid-1967 all 50 states, Washington DC, and the Virgin Islands had enacted laws concerning the reporting of child abuse. In accordance with these laws, reporting is discretionary in six states: Alaska, Missouri, New Mexico, North Carolina, Texas, and Washing-

ton. In all other states reporting is mandatory.

Soon after the laws were enacted, it became clear that several problems limited the effectiveness of reporting as a measure toward prevention, treatment, and control. Many physicians, especially those in private practice, continued to be either unaware of the provisions of the law or, though aware, were hesitant to comply with its requirements.

An even more serious problem in most communities is the inadequacy of special child welfare services. The inability to deal constructively with the abused child, his siblings, and his parents, once an incident is reported, may turn reporting into a futile formality. Monrad G Paulsen, of the University of Virginia, succinctly summarized the problem on the basis of his studies of legal protection against child abuse: "Reporting is of course not enough. After a report is made, something has to happen. A multidisciplinary network of protection needs to be developed in each community to implement the good intention of the law. . . . The legislatures which require reporting but do not provide the means for further protective action delude themselves and neglect children."¹⁰ Co-operative efforts between medical, welfare, and legal authorities to improve mutual understanding of the interacting roles is viewed by Cheney as the best chance to reconcile the needs and safety of the child with the constitutional rights of the parents.¹¹

Incidence

David Gil has developed a definition of child abuse for use in his Brandeis University study, "Non-accidental physical attack or physical injury, including minimal as well as fatal injury, inflicted upon children by persons caring for them," which is a sound basis for beginning an observation of the syndrome.¹² Despite the fact that a great deal has been written about the phenomenon of child abuse, it is discouraging to observe how little is really known about incidence rates and distribution problems. The national distribution of incidents reported in accordance with the law seems due to interstate differences of reporting laws, to interstate and intrastate variations of compliance with reporting provisions of the laws, and to possible variations in the identification and reporting of child abuse incidents among different social subsegments of the population. On the other hand, reporting rates are likely to include an unknown proportion of cases which, upon investigation, may not fit generally agreed upon definitions of child abuse.

According to Fontana, the abuse of children is probably the cause of the greatest number of deaths in children.¹³ Contrary to most authorities, David Gil feels that physical abuse of children does not seem to be "a major killer and maimer" and he states, in fact, that less than one third of the cases reported turn out to be cases in strict accord with his own definition. In a nationwide survey in 1962, Kempe compiled a total of 749 cases observed by district attorneys' offices and hospitals. Of this number, 78 children died and 114 suffered permanent brain damage. In only one third of these cases, proper medical diagnoses initiated court action. By 1969, with attending publicity, 2,169 cases were reported in New York State alone.

Kempe and Helfer have indicated that there are probably as many as 50,000 cases of child abuse in this country annually, and further estimate that 25% of the fractures occurring in children under age two are a result of abuse. Kempe and Helfer offer the suggestion that the incidence ranges from between 250 to 300 reported cases per million population per year. Epidemiologic data, though undoubtedly skewed by the influence of socioeconomic circumstances on reporting and case finding, indicate that boys are more likely to be abused than girls, blacks more often victimized than whites, and that younger children in general are most likely to be the objects of abuse.

Medical Aspects

The maltreated child is often brought to the hospital or private physician with a history of failure to thrive, malnutrition, anemia, poor skin hygiene, irritability, and other signs of obvious neglect. The more severely abused children are seen in the Emergency Room with external evidences of body trauma, bruises, abrasions, cuts, lacerations, burns, soft tissue swellings, and hematomas. Most severe injuries may include multiple fractures, subdural hematoma and injuries to the internal organs. Among other signs and symptoms which have been noted are cigarette burns, electric cord whip marks, and avulsion of the frenulum produced by the tendency of parents to jam the bottle into the baby's mouth.

Medical work-up of these unfortunate children includes X-rays of the skull, ribs and long bones; hematologic work-up, with careful evaluation of clotting function; and, if possible, photographs of the injuries.

According to Helfer, the family physician or pediatrician has a clear responsibility both to the abused child and his family. He must see this responsibility as an involvement with the

total family unit, and must not find himself caught up in the complex situation of alienating the parents in his attempts to help the child.¹⁴ He may have to assume several roles including medical advisor, marriage counselor, social worker, legal consultant, reporter of the facts, testifier in court, and, frequently, psychiatrist. The physician must make every effort not to render judgment or become angry. He must realize that the parents usually are seeking help, and he should keep the parents completely informed about what is going on.

Helfer cites as well the roles of the University Medical Center in research, teaching and service; information regarding the diagnosis and management of child abuse not only be conveyed to medical students, house staff, and area physicians; but also of carrying the message to community agencies, elected officials, and school personnel. Without this sharing and interchange of advanced knowledge with community agencies, abused children will continue to be neglected by the misguided efforts of the inexperienced.

Our Approach

The reasons behind the transition from public agencies to private in the management of abusive families have their origin both in fiscal realities and in a discontent with methodology in actual case management. Fiscal limitations in the public sector often make it impossible for these agencies to accomplish more than making an investigation of the incident and crisis placement for the child or children. A constant complaint is that they are unable to provide adequate counseling or follow-through on most families. In terms of case management, the obvious problem is in trying to provide comprehensive services to families in need when these services are only offered in the most fragmented and disorganized fashion in most areas of the country. Attempting to provide families with casework, homemaking services, psychiatric services, medical services, etc becomes an impossible nightmare of paperwork and red tape, which frustrates both patient and professional alike.

The team approach to coping with and helping abusive families and children has come to develop out of this past confusion. These teams are composed of professionals and nonprofessionals brought together to provide accessible, intensive, and comprehensive services to this target population.

A major goal is to induce positive changes in family dynamics so that the parents can maintain their parental responsibilities while insuring an adequate environment for the safe growth

and development of the children. Many of these programs have been generated by the concern of hospital-based physicians, social workers in public agencies, and some by personnel in outpatient hospital clinics. Some of these are carefully planned, whereas others are hastily put together; but each of them exists as a result of a felt need to provide better services. Best known of these are programs in Denver, Pittsburgh, and at Boston Children's Hospital.

In the spring of 1971, the Department of Pediatrics of Sinai Hospital developed an interest in making the phenomenon of child abuse a priority. There was precedent for this in the Denver project, and a feeling that more services were needed for this population in Maryland. Obvious problems and limitations in the local public agencies reduced their effectiveness to deliver services, as is the case in most states.

The Child Abuse Project takes the view that child abuse is a "social ill" stemming from an unhealthy environment within the family of the victim. Both psychological and social chains of etiology are hypothesized and long-term treatment by staff members educated in a variety of disciplines are the intervention modalities.

In conceptualizing how this project might be integrated into the framework of present service delivery systems, there were many considerations. Most important was recognition that Maryland law had vested the Department of Social Services with the responsibility for investigating and assessing the needs of each abusive family as well as formulating a treatment or continuing care disposition on each case. Further, the Division of Protective Services carried continuing care custody of those children who were to be placed, by court order, out of the home either on a temporary or permanent basis. Thus, it was clear that close ties should be established with the local Departments of Social Services in order to succeed in arranging for cooperation and an effective referral procedure.

Since the hospital was interested primarily in providing intensive therapeutic care for the families and children, rather than involving itself in the investigatory or custodial areas, clear notions of a separation of functions emerged reducing possible areas of conflict. Both the hospital and Departments of Social Services began to see that there could exist a situation where one agency could enhance the other's effectiveness and ability to deliver comprehensive, meaningful services.

In order to reduce community and inter-agency confusion, a "closed" referral system was

arranged with the understanding that the local Departments of Social Services alone would refer patients based on their judgments that the families could benefit by this opportunity to receive intensive services. In cooperation with the Department of Social Services, criteria were outlined in terms of what behavioral indicators would be assessed to make these judgments. Some of the criteria had been formulated by other projects that had been operational over various lengths of time. Once this task was accomplished, attention turned to the creation and organization of an effective team to operate within the framework of a community general hospital.

The Sinai Hospital Child Abuse Program is a multidisciplinary team approach to aiding families in which a child has been physically abused. The team consists of a pediatrician, social worker, nurse, psychiatrist, and community aide. Roles have remained distinct within the team with much of the primary family service being provided by the person with the least formalized training, the community aide.

The community aide is a 30-year-old, black married female. She is a high school graduate with two years of experience in computer operations. Her previous work experience includes assisting in visual testing of school children, working in a hospital medical records department, and being a short order cook. Her major function within the Child Abuse Program consists of meeting with family members within their own home; in no way is she expected to function as a psychotherapist, but rather her role is to act as a good friend and behavioral model to the abusive parents.

Kempe has pointed out that about 90% of abusive parents have themselves experienced much emotional deprivation and poor mothering during childhood; thus, the community aide serves also as a didactic model of what behavior constitutes "good mothering." Parents who abuse their children frequently experience recurrent crisis situations which could again result in child abuse; consequently, it has been imperative that the community aide be available around the clock for any emergency situation.

The social worker has three major roles. He is the administrative coordinator of the program, as well as the family therapist for the parent (in single parent families) or parents. Additionally, he provides individual supervision to the community aide, thereby coordinating team goals in a common direction. The pediatrician is available for medical evaluation on the abused

child as well as other family members and for consolidating pertinent medical data from other area physicians.

It is known that abused children often suffer from neurologic deficits as well as other physical problems. Medical care in many of our families has been fragmented with involvement of many different clinics and agencies; thus, the nurse functions as a liaison in coordinating past medical and social agency data so as to bring into focus a clearer perspective of the family's current needs.

The psychiatrist provides consultation regularly to the coordinating social worker and is present at all the weekly meetings (one and one half hour team meetings), wherein new families are considered for acceptance into the program. Following social background provided from preconference interviews, the psychiatrist interviews the parents in the presence of the team. Thereafter, psychodynamics operating within the family system are discussed and a team decision is made concerning acceptance of the family into the program. If a family is accepted, a preliminary treatment approach is decided upon. If a family is felt unlikely to benefit from the program, alternative recommendations are made to the referring agency detailing the best approach for assisting the family. All team members have input into the decision-making process regarding acceptance of a new family into the program and in terms of a treatment disposition.

Team meeting time is also utilized to periodically reevaluate families currently in the program. The psychiatrist's major function is to assist in understanding dynamics, but everyone has responsibility for providing input into the discussion. Much of the input data at the follow-up sessions is provided by the community aide, who has had the best opportunity of observing the family interaction in the home.

Results

Thus far, our team has provided services for nearly 30 families. We have developed some basic research instruments which have been adapted to the study of child abuse and which will be reported in another paper. These are designed to enable us to establish criteria by which potentially abusing families may be identified and abuse prevented.

Engagement in the services of the project reduced the potential for child abuse very markedly. Confirmation of this finding is to be seen in the fact that, to the project's knowledge, no further instance of physical abuse of the child

in question has been reported either by a member of the project staff or by a staff member of the referring agency in an active case.

Conclusions

It is our impression that the program has been serving many of the "right" families. These families have experienced long-standing psychosocial stress and the abuse incident does not represent a single, impulsive act; rather the abuse is an integral part of a family interactional pattern, which is being stressed beyond its limits of tolerance. The families require assistance in a multitude of areas; to date, we feel our multidisciplinary team approach has been able to service most of these needs.

Future evaluations will focus seriously on cost-benefit calculations as the project becomes freer to utilize differential service strategies. Only brief consideration was given to such relationships during the present project. On a preliminary basis, it would seem that the project expends approximately \$2,600 per year per active case carried throughout the year. This figure may strike an uninitiated reader as high. We suggest that it is rather an example of economical use of resources. Comparing cost figures with those typical of medical clinics, it must be remembered that each of the families served by the project came with a "disease" whose presence has been established.

Thus, for comparison purposes one should compare families served by the Child Abuse Project with those children served in a medical clinic who are found to be suffering from a defined, sometimes fatal, disease of variable prognosis rather than with a general clinic population. A figure such as \$2,600 per year strikes one as low for a full year's treatment of the commonly afflicted pediatric patient. Included in the calculation of benefits, the prevention of abuse to siblings of the child himself raises the ratio in the direction of benefit by a considerable margin.

Future expansion of the project will be undertaken, keeping in mind the advantages of limited size evident in this first year's assessment. Rather than simply increasing the number of cases served, thus increasing geometrically the possibilities for systemic problems, consideration will be given to establishing satellite units. Limiting each such unit to a maximum of twice the current size would avoid the situation in which administrative direction and professional supervision need to be provided through elaborated structures.

A general finding about the use of para-pro-

professionals is worthy of mention in relation to a project in which the community aide has played such an important role. Attention needs to be given to the development of a career ladder for para-professional personnel.

It is planned to continue our Child Abuse Program with little modification of our operational protocol. Two community aides, rather than one, will be providing much of the direct client care, and it is hoped that the active case-loads can reach 30 to 40 families. In 1970, however, there were 567 reports of suspected child abuse in Maryland with 391 in Baltimore City alone. It surely will not be possible alone to service a significant amount of these families due to our intensive, long-term approach to each family.

It is our hope this paper will serve as a stimulus for others to develop an organized, comprehensive program for the treatment of abused children and their families. We have only reported some of the major preliminary findings to date; in subsequent papers, we will be reporting in more detail the results of our program.

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Although not a sports aggregation, we might liken the employees of the Medical and Chirurgical Faculty to a team. In fact, they are a team and every working day are deeply involved in teamwork to keep the affairs of more than 5,000 employers and "stockholders" moving efficiently and with dispatch.

This, then, is an introduction to those 22 full-time members of the Staff team, capsuling their team duties, listing significant memberships and honors, taking a peek at their outside interests and hobbies, picturing their likenesses, and listing the year they joined the team.

John Sargeant, 1958

The report will be in alphabetical order except for the "player-manager"—John Sargeant, Executive Director, who has been the chief strategist since joining the team in 1958.

Serving as the chief executive and general manager of the affairs of the Faculty, under the direction of the Officers, Council, and House of Delegates, he is charged with this responsibility under the By-laws.

Each component medical society can count on at least one visit per year from him to keep their membership fully apprised of Faculty activities.

He also serves as legislative representative during sessions of the General Assembly and meetings of the Legislative Council.

Currently serving as President of the Maryland Society of Association Executives, he has the honor

of being one of only 75 executives in the national association entitled to use "CAE" after their names; CAE is the acronym for Certified Association Executive. This coveted honor is awarded to individuals who qualify by examination and who maintain stringent educational activities.

His chief interests are his wife, Jeanne, and two daughters, Hilary and Meredith.

His principal hobby is his prize coin collection.

Terry Bromwell, 1969

Terry is Secretary in Mrs Ritchie's section, assisting with the myriad duties connected with the annual and semiannual meetings, Faculty sponsored symposia and seminars, Faculty committees and subcommittees.

She also occasionally serves as movie projectionist and slide machine operator.

"My main interest at present is #17 of the Baltimore Colts (Sam Havrilak), whom I plan to marry in January," the pretty-as-a-picture brunette proudly reports. That's the old team spirit, Terry!

Her hobbies: sports (naturally) and sewing.



Terry J Bromwell



Gloria A Camodeca



Elizabeth L Carter

Gloria Camodeca, 1969

As Bookkeeper in the financial-statistical-membership section headed by Joe Harrison, Gloria operates the billing machine, rendering financial statements and paying Faculty bills.

She also processes dues bills and reports members' payments to the computer.

She and husband Tom are active in the Moose of Glen Burnie. Bowling, baseball, reading, sewing, and travel are among her varied interests and hobbies.

Elizabeth Carter, 1968

As Secretary to Connie Galton, Betty turns out a large volume of correspondence with neatness, accuracy, and dispatch.

Betty is also responsible for all the administrative files and is the person on whom the harried executives call when an official file search is needed.

Requests from the medical profession for brochures and informational booklets also receive her prompt attention.

All of her non-Med-Chi hours are devoted to her husband, Kenneth, and their three children; Karen, Paige, and Leslie.

Doris Cicchini, 1968

As one of Joe Harrison's three "Gals Friday," Doris works with Gloria Camodeca and Novella Wallace in the financial-statistical-membership section. They work as a team in many of their duties.

Keeping the various mailing and membership lists up to date occupies most of her time.

Doris is in constant contact with the Faculty's data processing service in accomplishing her duties of maintaining the membership roster.

She is also responsible for billings for Journal advertising and other billings.

Sewing, housework, bowling, and travel are her consuming interests away from the office.

Mary Dixon, 1968

Mary is the only person to get to the office ahead of Mr Sargeant; they are both real early birds!

She doubles as secretary-receptionist until the full team arrives at the official starting time of 9:00 AM.

Mary devotes a considerable portion of her time to addressing and readying the various bulk mailings for the Faculty.

She and Laura Mae Frazier team up in the operation of the Mail Room and its related equipment.

Her husband, Pete, drops her off at the Faculty front door on his way to work with regularity but is sometimes late in picking her up past the 5:00 PM closing time.

Collecting antiques, housework, reading, and some sports occupy her off-duty hours.



Doris B Cicchini



Mary C Dixon



Katherine J Downey



Laura Mae Frazier

Katherine Downey, 1965

As Administrative Assistant for the Med-Chi Insurance Trust, Katherine handles the multitude of details involved in properly administering the insurance programs for the Trust.

She is a walking encyclopedia in this respect, and always has, or can readily locate, the proper answer for the inquiring member or prospective member.

She and her husband, Sam, spend all the time they can at their country home in the Blue Ridge Mountains near Harper's Ferry W Va. Trying to get a plumber to do some required plumbing has been a prolonged and exasperating project for her; she has even considered calling on the "White House Plumbers"!

Art, music, swimming, boating, gardening, and sewing are other off-duty activities.

Laura Mae Frazier, 1963

Laura Mae may not be the first one in the Faculty building each morning, but she definitely is the last one out each evening, making certain that all is secured before she departs.

Her duties often involve catering to meetings of the Faculty officers or committees when a dinner or reception is a part of the meeting.

You can also count on her having Osler Hall in full readiness for all scheduled meetings.

She works with Mary Dixon in operation of the Mail Room and in making special mailings.

Constance Galton, 1964

As Assistant to the Executive Director, Connie is engaged in numerous staff committee meetings, writing minutes, and attending correspondence.

She often attends meetings of other agencies, representing the Executive Director.

She serves as liaison between Mr Sargeant as legislative agent and Faculty members during sessions of the General Assembly.

And, at other times, she is occupied in assisting Mr Sargeant in the administrative details of the office.

She is a member of the American Association of Medical Soci-

ety Executives.

Being a graduate of speech training courses by SKF and the AMA is especially helpful to her in staff work with the Public Relations Committee.

Dancing (she's a real Ginger Rogers), bowling, swimming, theater, and politics are among her many interests.



Constance E Galton



Joseph J Harrison

Joseph Harrison, 1963

As Comptroller, multi-talented Joe is directly responsible for all of the Faculty's financial affairs. This also applies to statistical and membership operations.

Among his other official titles are Secretary, Med-Chi Insurance Trust; and Treasurer, Maryland Medical Political Action Committee.

Joe really controls the purse strings; being a CPA gives him the know-how to do that most effectively and efficiently.

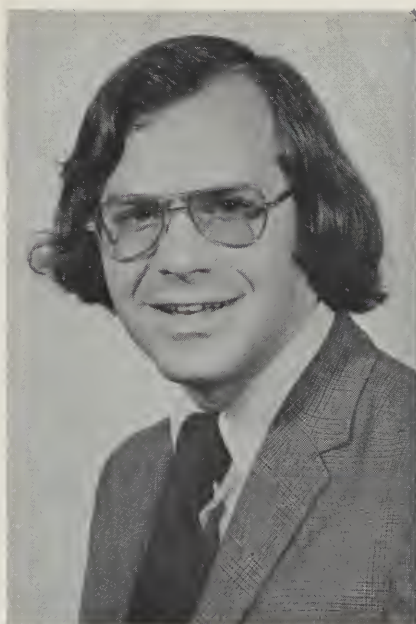
And he is a most welcome sight to Med-Chi employees on semi-monthly paydays!

Although he is most affable, the local advertising representative says she just knows that he cries all the way to the bank.

An interest in financial matters carries over into his off-duty hours, for he serves as Treasurer of the Catonsville Summer Theatre.

A family man (he and his wife, Marie, have five children), he is a natural as Chairman of the Board of Youth at his church.

Little League, bicycling, and tennis help to keep him physically fit.



Joseph E Jensen

Joseph Jensen, 1971

Assistant Librarian Joe Jensen operates the MEDLINE terminal, installed earlier this year to provide computer-produced bibliographies for doctors and allied health personnel throughout Maryland.

Joe selects new books to be purchased for the library with available funds.

He supervises the acquisition and cataloging of new library books and the updating and maintenance of the library's card catalog.

His interest in library work is reflected in these memberships: Medical Library Association, Special Libraries Association, American Society for Information Scientists, American Association for the History of Medicine.

The Colorado native is a qualified instructor in mountaineering and rock climbing; so, if you are interested in scaling Mt Whitney, Pike's Peak, or some other lofty mountain, Joe's your man. Almost any weekend, you will find him in nearby Maryland, Virginia, or West Virginia scaling sheer cliffs or instructing classes for beginners or intermediates.



Anna Wynde Leake

Anna Wynde Leake, 1929

With employment dating from October 1929, the widowed Anna Wynde Leake, Executive Assistant, is the "senior member of the firm."

Gran'ma, as she is affectionately called by her peers, reaches compulsory retirement age in 1974.

Both she and Med-Chi have come a long way since 1929; her departure will leave a void, for she has a wealth of knowledge acquired over these many years.

Presently, she helps with Executive Committee, Council, and House of Delegates meetings in preparing for them and in the related mailings and follow-up actions.

Physician's Defense Panels receive her attention, as does the Woman's Auxiliary.

The gold chain and locket she is wearing in the accompanying picture were presented to her in April 1970 in Osler Hall on behalf of the Faculty. This was on the occasion of recognition for completion of 40 years of service. It is inscribed: "AWL Med-Chi 1929-1969" and also includes a miniature embossed gold caduceus.



Esther S Magladry



Lester H Miles



June L Miller

Esther S Magladry, 1973

The youngest member of the team in point of service, Esther serves as Secretary to Mrs Ritchie.

Much of her working day is involved with the Committee for Program and Arrangements.

She also devotes a large portion of her time to the "million and one" details connected with the annual and semiannual meetings.

Music and her nine children, with all of their varied interests and activities, keep her on the go away from Med-Chi.

A member of the American Guild of Organists, she is Assistant Choir Director and Organist at Epiphany Lutheran Church.

Lester Miles, 1971

As Managing Editor of the *Maryland State Medical Journal*, Les, guided by editorial policies set by the Editor and the Editorial Board, coordinates all facets of Journal production.

As a one-man staff, he has the assistance of various contributing editors, a proofreader, and the Executive Director.

After 37 years with Exxon (and predecessors), Les took early retirement in 1968. An unsuccessful

fling at golf, a rubber raft trip down the Colorado River through the Grand Canyon, a pre-Olympics visit to Mexico, and an ill-fated hiking expedition in the White Mountains of New Hampshire highlighted his retirement years.

He is a member of the Board of Directors of the Maryland Association of Communicators and Treasurer of the Mountain Club of Maryland.

He tries to stay in shape by jogging two miles every morning before coming to work and climbing the four flights of stairs to his "Mt Washington" office.

June Miller, 1961

June Miller, Receptionist and PBX Operator, as a general rule, is the first person contacted by callers or visitors.

Her extensive background in this type of work enables June to render prompt, efficient information and guidance to those persons needing our services.

Contingent upon the demands of her position, June also assists with the clerical duties of the administrative staff.

June dabbles in art, music, and raising flowers, loves nature, the outdoors, and traveling.

"My main interest is caring for my family and home and living in my own quiet little corner of the world with as much peace and pleasure as possible," says June.

Patricia Munoz, 1972

Pat, Circulation Assistant for the Library, occupies the desk just inside the second-floor library door, and is the first person with whom most library visitors (and callers) deal.



Patricia Munoz



Connie L. Norris

She's very adept in answering quick reference questions and is a real library booster.

Pat supervises interlibrary loans and the photocopying and maintenance of the periodical collection. She also performs secretarial duties for Mrs. Sanford.

Her husband, José, a career military man, is presently on assignment in Korea. She and little José Antonio are anxiously awaiting his return.

Stamp collecting, bowling, and sewing are her hobbies.

Connie Norris, 1973

Since Connie joined the team this spring, we now have two red-headed Connies (the other being Connie Galton).

Connie has absorbed the overload on Connie Galton and Genevieve Ritchie and now provides staff services to the following committees:

Medicolegal, AMA Membership, Continuing Medical Education, Occupational Health, Medicine and Religion, Emergency Medical Services, Joint Practices, HAVES Inc, Utilization Task Force, and



Jo Ann Ptak

the Maryland Commission on Medical Discipline.

Her many outside interests include crocheting, needlepoint, piano, organ, gardening, camping, and politics (the result of a government major at the University of Maryland where she received her BA in 1972.)

As church organist at the Tabernacle Baptist Church, she and Esther ought to get together for a joint concert!

Jo Ann Ptak, 1969

When we asked Jo, Secretary to the Executive Director, to describe her job, she said, "keeping Mr Sargeant happy from 9:00 AM to 5:00 P.M."

Since he always appears to be in a reasonably happy frame of mind, she obviously meets those requirements.

(As an aside, this reminds me of the elevator operator who, when asked to describe her job, said, "50% up, 50% down.")

Jo and her husband, Lou, are avid sports fans.

She also listed cooking and shopping as hobbies. Lou's appearance



Genevieve Ritchie

shows that he enjoys her cooking; we really can't vouch for the shopping part, however.

Genevieve Ritchie, 1946

As Executive Assistant, Genny has the responsibility for all arrangements for the annual and semiannual meetings, including exhibits, correspondence, publicity, designing, compiling and printing of programs, etc.

As Dr Schaefer commented at the 1972 Presidential Banquet, the Annual Meeting is her "baby" from time of conception until delivery. And she is as proud (and as exhausted) as a new mother at the conclusion of each Annual Meeting!

She also finds time to staff other Faculty committees including Emotional Health and Preventive Medicine and Public Health.

Arranging seminars, as required, also comes under her domain.

Her membership in the Professional Convention Management Association aids her in properly discharging her duties.

As to her outside interests, she says, "Four Fs: family, friends, food, and fun!"



Elizabeth G Sanford

Elizabeth Sanford, 1963

As Librarian, Mrs Sanford oversees all the activities of the Faculty library, which totals over 97,000 volumes. This includes administration, book selection, and general reference activities.

The high honor and esteem accorded our Library in medical and library circles is ample proof of her success.

To enable her to better perform her duties, she maintains active membership in these organizations:

Medical Library Association, Special Libraries Association (past president of the Baltimore Chapter), Baltimore Hospital Librarians Association, Mid-Atlantic Task Force of Region IV Medical Library (National Library of Medicine).

She and her husband, Gil, share their interests and hobbies including flower gardening, antiques, swimming, travel, and music.

Thomas Sharp, 1967

Thomas' first duty each morning is to raise the American flag, with its lowering being just about his last assignment each evening.



Thomas Sharp

In between, as building custodian and utility man, he sees that everything is ship-shape on all five floors of the Faculty building.

When not otherwise engaged, he works with Mary and Laura Mae on special mailings or on special projects assigned by Joe Harrison.

Novella Wallace, 1973

It was only a short trip around a building partition when Novella moved from Secretary for the Maryland League of Nursing to Med-Chi in March.

She now does secretarial work for Joe Harrison and works with Gloria and Doris in the three-fold duties of the financial-statistical-membership section.

She is the person who processes membership applications and adds new members' biographical data to the computer file.

Novella also prepares the bank deposits and maintains the inventory of office supplies.



Novella H Wallace

This concludes the introduction of the Med-Chi staff team.

We trust that, as members of the Faculty, this introduction to your staff has given you a better insight into what makes us "tick."

We are here to serve you with our best "first-team" effort and pledge to continue to help you to make the Medical and Chirurgical Faculty of the State of Maryland a winner among state medical societies and a respected and honored name in medical circles.

LESTER H MILES
Managing Editor



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are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain¹⁻³ leading to this conclusion, and one⁴ in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of

fluid retention, conditions which might be influenced by this factor such as epilepsy, migraine, asthma, cardiac or renal dysfunction require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

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1848

United States gained territory from Mexico

1886

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Baltimore City Medical Society

Drug Use and Abuse

DONALD M PACHUTA MD
Editor

NEW FEDERAL REGULATIONS FOR THE USE OF METHADONE

Reprint requests to Dr Pachuta c/o Baltimore City Medical Society, 1211 Cathedral St, Baltimore Md 21201.

In May 1973, a new set of federal regulations governing the use of Methadone was published. Shortly thereafter, the Food and Drug Administration (FDA), the Special Action Office for Drug Abuse Prevention, and the American Medical Association's Committee on Alcoholism and Drug Dependence jointly produced a document explaining these regulations. Under the new regulations, only pharmacies approved by the FDA to dispense Methadone will be allowed to do so. This includes hospital pharmacies, community pharmacies, and pharmacies involved in Methadone Treatment Programs. Thus, not all pharmacies will have the drug available for prescription.

Methadone for Chronic Pain

The regulations state that in individuals receiving Methadone for chronic pain, physicians should attempt, to the extent feasible and consistent with the best interests of the patient, the use of an alternate drug. In those cases where, in the attending physician's clinical judgment, Methadone is considered the drug of choice, it is the physician's responsibility to document that this is so, and then identify a source of Methadone. Once again, these sources will be a hospital pharmacy approved by the FDA to dispense Methadone for inpatients and outpatients for analgesia in cases of severe pain, or a community pharmacy approved by the FDA to dispense Methadone for analgesia in cases of severe pain. Generally, such approval for a community pharmacy is obtainable when no hospital pharmacy has been approved in a specific geographical location.

In hospitalized patients who are "medically" dependent on Methadone the following guidelines apply. In such cases it is suggested that the attending physician carefully evaluate the physi-

cal and psychological status of his patient and first of all attempt to detoxify him as an inpatient. If multiple detoxification attempts fail, and the patient cannot maintain a drug-free status, then alternate medication should be considered. In the event that all of these attempts are unsuccessful, and Methadone must be utilized, the attending physician should refer the patient to an approved Methadone Treatment Program where he can be detoxified on an outpatient basis or, if necessary, maintained on the drug.

It is the responsibility of the State Agency to see that Methadone is available where justified medical needs arise. Furthermore, hospitals should be encouraged to apply for approval from the State Authority and the Food and Drug Administration to have Methadone available for use on an inpatient and outpatient basis for analgesia in severe pain, and for inpatient detoxification and temporary maintenance.

Methadone Treatment of Narcotics Dependence DETOXIFICATION

The new guidelines contain very rigid restrictions on the prescribing of Methadone, as well as new definitions regarding a variety of programs and modalities. A Methadone Treatment Program is now defined as a program approved by the State Authority and the FDA to utilize Methadone for treatment of narcotic-dependent individuals. This treatment program must provide access for its patients to a full range of rehabilitative and medical services. In such a program, Methadone may be used for either detoxification, which must be accomplished within a time period of three weeks, or maintenance treatment, which consists of the administration of Methadone over an extended period of time. Methadone Treatment Programs are encouraged

to offer both detoxification and maintenance treatment.

Detoxification must be done **only** under the following circumstances: 1) as an outpatient under the auspices of a Methadone Treatment Program; 2) or on an inpatient basis, but only in a hospital which has been approved by the State and the FDA under conditions for use of Methadone in hospitals. Hospitals wishing to provide detoxification treatment on an outpatient basis would need to make an application to be a Methadone Treatment Program. In acute detoxification over three weeks, no take-home medication is permitted. The patient must come to the Program seven days a week for on-site, observed, Methadone ingestion. Thus, a private physician in his office who is not part of an approved Methadone Treatment Program **cannot** detoxify narcotic dependent individuals with Methadone.

The three-week time constraint and the definition of detoxification apply only to persons where this is done acutely. Patients who are on Methadone maintenance and already stabilized in a treatment program are not defined by the regulations as "detoxification." These individuals may be gradually withdrawn from Methadone over an extended period of time depending on what is deemed clinically appropriate.

MAINTENANCE

Methadone maintenance treatment is defined in the new regulations as the administration of Methadone over an extended period of time (exceeding three weeks) in conjunction with the provision of necessary rehabilitative and medical services as outlined in the regulations. An eventual drug-free state is the treatment goal; thus, maintenance treatment shall be discontinued within two years after initiating such treatment unless, based upon the clinical judgment recorded in the clinical record of the patient, the patient's status indicates that such treatment should be continued for a longer period of time. Any patient continued on Methadone for longer than two years shall be subject to periodic reconsideration for discontinuance of such treatment.

A **Medication Unit** is defined as a facility; eg, a physician's office, a clinic, an industrial plant facility, a community pharmacy, etc which has been **approved** by the State and the FDA as **part of a Methadone Treatment Program** to provide for the administration of Methadone and the collection of urine samples for patients who are on Methadone maintenance treatment. The patients referred to such a unit must have reached

a stable dosage level and have shown satisfactory evidence of progress toward rehabilitation. Thus, a private physician who is not approved by the State and the FDA as part of a Methadone Treatment Program cannot administer Methadone to these patients requiring it. In order to do so, he must seek and be granted approval both by the State Drug Abuse Administration and the FDA as a part of a Methadone Treatment Program, in which case his office would be considered a medication unit.

The new rules require that, for admission to a Methadone Maintenance Program, a patient must have a history of having become physically dependent on an opioid substance at least two years prior to the time of evaluation. This means that the onset of physical dependency, ie, had the individual stopped opiate use at any time during this period he would have experienced a withdrawal syndrome. The regulations state that this is generally synonymous with the daily use of opioid drugs for some extended period of time, although the individual need not have been continuously physically dependent on these drugs during the two-year period. There is no specific length of time of physical dependence history required for detoxification. It is only necessary that the person currently be physically dependent at the time and in need of substitutive treatment.

For treating patients under the age of 18, parental consent is required by the Drug Abuse Administration of Maryland. When such consent is not easily obtained, treatment may be rendered with a written consent of the minor himself.

The regulations contain a great deal of information on who may be a Program sponsor, the requirements for supporting laboratory and rehabilitative services, the staffing patterns required for the operation of Methadone Treatment Programs, and numerous other details. This information can be obtained, if desired, from the Baltimore City Medical Society, or the State Drug Abuse Administration.

Role of the Physician

Any physician may participate in a Methadone Treatment Program in a number of ways, all of which require approval by the appropriate agencies and the filling out of the appropriate forms. Any physician may be a Program sponsor; a medical director; or the physician responsible for prescribing, dispensing, or administering Methadone. A physician may provide any medical services except for prescribing, dispensing, or administering Methadone (unless he is approved to do this by the appropriate agencies). These

services may be performed at the Program site or at an affiliated institution such as the hospital. However, he must be listed as performing these services on the appropriate forms. Any physician may be authorized by the Program sponsor to operate as a "Methadone Treatment Medication Unit." Again, he must be listed on the appropriate forms and be approved by the appropriate state and federal agencies. The medical responsibilities of a physician in a Methadone Treatment Program, regardless of what service he may perform, are the same as would exist in any type of medical practice. He is held professional, legally, and ethically responsible in his practice of medicine with drug-dependent patients.

The private physician may treat drug dependent patients with Methadone **only** under the following circumstances:

1) Detoxification can be provided to drug dependent patients in an **approved hospital** on an inpatient basis without filing an application as Program sponsor for a Methadone Treatment Program. Again, the hospital must be approved by the appropriate agencies.

2) Temporary maintenance treatment can be provided in an **approved hospital** to a drug-dependent patient who is hospitalized for treatment of a medical condition other than drug dependence and who requires temporary Methadone maintenance treatment during the critical period of his stay in order to prevent the development of acute narcotic withdrawal. Here also, the hospital must be approved by the appropriate agencies.

3) A private practitioner may become a Program sponsor, in which case he will be governed by the same requirements as any other Program **sponsor; ie, he must develop** a treatment Program which can provide the full range of comprehensive services. Supportive services may be made available through documented contractual agreements with other organizations and institutions. The staffing pattern must meet the same requirements as any other Program. It is also his responsibility to see that the patient receives the requisite medical and social rehabilitative services under these circumstances. In order to do this he must be approved by the appropriate state and federal agencies.

4) A physician may become a "medication unit" as defined above.

If there are any questions regarding these regulations, it is suggested that physicians contact the medical societies or the Drug Abuse Administration for further clarification.



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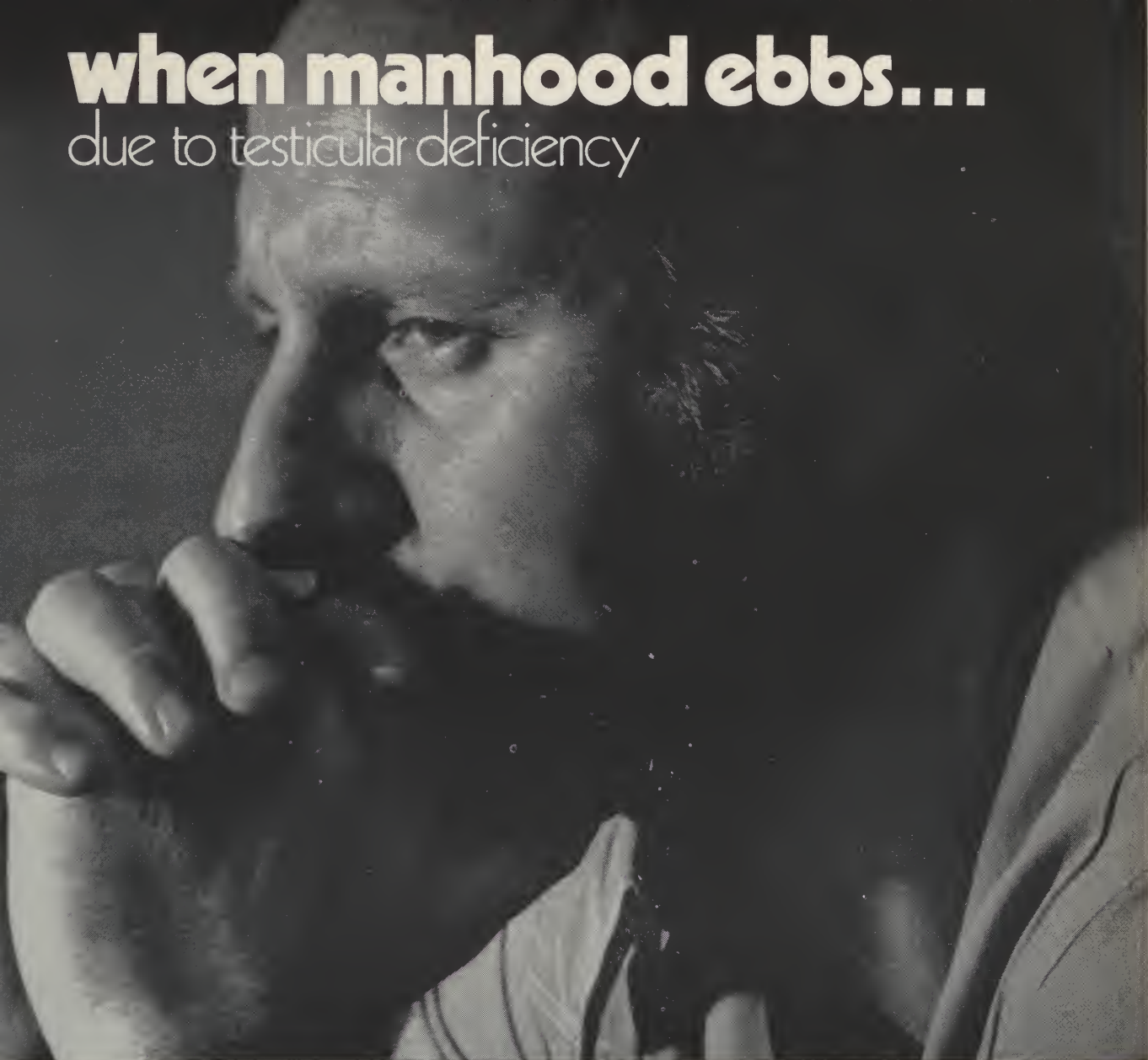
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Indications in the male: Primary indication in the male is replacement therapy. Prevents the development of atrophic changes in the accessory male sex organs following castration:

1. Primary eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Those symptoms of panhypopituitarism related to hypogonadism. 4. Impotence due to androgen deficiency. 5. Delayed puberty, provided it has been definitely established as such, and it is not just a familial trait.

In the female: 1. Prevention of postpartum breast manifestations of pain and engorgement. 2. Palliation of androgen-responsive

advanced, inoperable female breast cancer in women who are more than 1, but less than 5 years post-menopausal or who have been proven to have a hormone-dependent tumor, as shown by previous beneficial response to castration.

Contraindications: Carcinoma of the male breast. Carcinoma, known or suspected, of the prostate. Cardiac, hepatic or renal decompensation. Hypercalcemia. Liver function impairment. Prepubertal males. Pregnancy.

Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced

ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.

Adverse Reactions: Acne. Decreased ejaculatory volume. Gynecomastia. Edema. Hypersensitivity, including skin manifestations and anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.

How Supplied:

2 mg—bottles of 100 scored tablets.

5 mg—bottles of 50 scored tablets.

10 mg—bottles of 50 scored tablets.

For additional product information, see your Upjohn representative or consult the package circular.

J-3262-4 MED B-6-S (MAH)

*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. 1; Beeson, P. B. and McDermott, W. eds. Philadelphia W. B. Saunders Co., 1971, p. 1816.

Upjohn

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Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

[†]For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



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Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT ¹
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

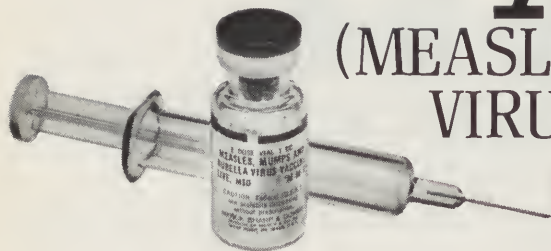
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

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For a brief summary of prescribing information, please see following page.

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No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID₅₀ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID₅₀ of mumps virus vaccine, live, and 1,000 TCID₅₀ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

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Words of Praise

One day a man called wanting information about a certain Baltimore physician (you'd be surprised at the questions sometimes asked about you!). After explaining the Faculty's policy relating to this type of information and giving the record from the specialists' directory, which was entirely satisfactory, he asked: "Tell me what else you people down there do." After I had talked several minutes describing the library's functions, then branched out to the other services the society affords, he said: "Gee, that's fine, thanks a lot."

Sometimes it is rewarding to know someone appreciates our efforts and that we perform a really valuable service to the community.

Another day a young woman called and, expecting the usual request for directory information on a doctor or for books, journals, or searches, Mrs Munoz was quite surprised to hear a different type of question. The friendly voice said: "I've been so pleased with my new doctor, I wonder if the Medical Faculty couldn't send out cards on a new doctor to all the neighborhood? He isn't well known yet because he just moved here and I just thought it would be very appropriate if the medical society announced his practice so everybody would know about him." If that physician knew how complimentary she was, he would really stand proud.

Of course, the comments aren't all like this!

Peripheral Library Services

One of the news sheets that arrives in the library periodically is distributed by the Clinical Center, National Institutes of Health, Bethesda. The purpose of these notices is to recruit patients with varying diseases that local physicians and hospitals are unable to diagnose or treat successfully. Physicians may refer such patients to the Center for participation in studies being

conducted there and, in turn, the patients are returned to the care of their own physicians who are furnished a report of findings from the Center's study.

This is the Clinical Center's method of securing subjects for their research studies and a governmental function. A file of these notices is maintained in the library and may be consulted there.

Baltimore Hospital Librarians' Association

The Baltimore Hospital Librarians' Association will meet at Good Samaritan Hospital on November 15. If you are new in the Baltimore or Maryland area and a medical librarian, be sure to contact the president of this organization, Mrs Elizabeth Streett, Librarian, School of Nursing Library, Union Memorial Hospital, 3301 N Calvert St, Baltimore Md 21225, (301) 235-7200, ext 488. She will be glad to put your name on the mailing list and urge you to become active in this group. Any hospital, medical school, or other health-related community librarian is welcomed.

Other meetings will be in January, March, and May 1974, with specific dates and programs to be announced soon.

Staff News

We regret to announce the resignation of Mr Michael Murray from the library staff. Mike had worked with us in the History of Medicine Section for several years and was familiar with most of the collection in that field.

Medline Notes

We got a reprieve on MEDLINE charges through August 13, but still at this writing do not know exactly what will happen eventually. However, keep your requests coming and for the time being Med-Chi will not be charging for searches.

NEW ACCESSIONS — BOOKS
(Arranged by Subjects)

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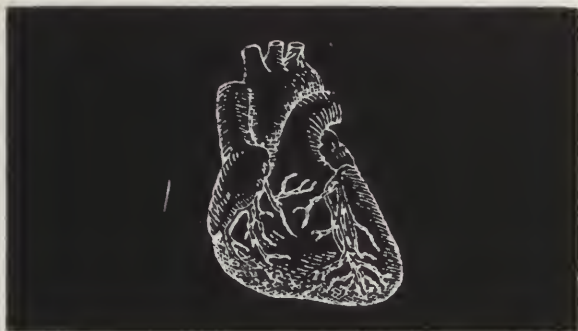
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ADVANCES IN HYPERTENSION

JAMES J H CAREY MD

Dr Carey is Director, Dialysis Unit and Associate Head, Division of Nephrology, Maryland General Hospital, Baltimore.

Abstract

Hypertensive disease has been largely redefined over the past several years. The evaluation and therapy of the hypertensive patient has been modified through the application of newer concepts and drugs, while greater understanding of underlying etiology promises still more advances in the months and years to come. This paper describes some of these advances and their impact on clinical medicine.

Hypertension Defined

No one to date has successfully defined the point at which normotension becomes hypertension. Each textbook sets arbitrary limits; each practitioner chooses to treat at some equally arbitrary level. It is apparent that the onset of hypertension is elusive, suggesting one should avoid rigid, numerical limits in its definition. It is interesting that several studies show that the deleterious effects of high blood pressure are consistently associated with blood pressures previously considered in normal- to high-normal ranges. This is most dramatically shown by actuarial data, in which increasing mortality is linearly related to increasing blood pressure without regard to so-called normal or hypertensive ranges (see Table 1).¹

Freis has reported that the cooperative Veterans Hospital study showed a clear decrease in morbidity in treated *vs* nontreated patients over diastolic ranges previously felt not to require therapy.² Naturally, there is a practical limit to the implication that one treat every patient in the borderline zone of 90 diastolic to 105 diastolic, since treatment of these patients would subject many to long-term treatment, perhaps without justification. The cost/benefit ratio of

Table 1

Mortality ratios* for men according to groups of systolic and diastolic blood pressure readings from the Actuarial Society of America and the Association of Life Insurance Medical Directors, 1941

Systolic Reading (mm Hg)	Diastolic Reading (mm Hg)				
	64-83	84-88	89-93	94-103	all
118-132	90	91	99	97	92
133-142	99	107	118	134	110
143-152	133	137	141	173	148
153-167	186	178	189	237	210
All	95	100	116	151	106

* Actual to expected deaths (expected=100)

treating this group would be high. Redefining hypertension in terms of degree rather than kind is a useful intellectual achievement but disconcerting from a practical point of view. As a result, a decision to treat any individual must rest on an assessment of a variety of factors, besides the purely numerical.

One important aspect concerns race. Blacks have a greater tendency to have elevated blood pressure in all age groups. In particular, hypertension in the younger Negro appears to occur more frequently and is a more severe disorder. Treatment of the young black patient must be initiated at lower levels than in his white counterpart. This is true for either sex.

Secondly, the existence of a strong family tendency towards hypertension must be considered. Borderline elevation in the face of a positive history may tip the balance in favor of therapy. Thirdly, the severity and morbid consequences of high blood pressure are worse in males than in females. Therefore, the sex of the patient may bear on the decision to treat. Lastly, the impending onset or existence of one of the recognized complications of hypertension should encourage one to begin treatment. Evidence of cardiovascular compromise (by physical examination, X-ray, or EKG), transient cerebral ischemic attacks (TIAs), renal impairment, and visual disturbances should be considered indications for therapy.

It must be emphasized that it is incorrect to withhold therapy in patients suffering TIAs on the grounds that one may precipitate stroke. Decreased mortality has been documented in hypertensive patients with TIAs who have been treated *vs* the nontreated hypertensive group.³ Whether or not renal insufficiency may be worsened by therapy is harder to come to grips with. Mild hypertension that may be seen with renal insufficiency should be reverted to "normal" levels. There is much debate as to whether more severe blood pressure elevations in face of renal impairment should be lowered below a diastolic pressure of 90-100 mm Hg. The recommendation here is to approach 90 diastolic in these patients.

In this section, we have stated that the deleterious effects of blood pressure are generally acknowledged to occur at lower levels than previously appreciated. These effects include cardiac disease leading to coronary artery disease, left ventricular failure, and congestive heart failure. Arterial disease may become manifest by atheromata, renovascular and ocular disease, and the minute Charcot-Bouchard aneurysms in the cerebral cortex. The latter are probably the source of cerebral hemorrhage.

Up to this point, the discussion has centered around diastolic hypertension with the understanding that the pressure level has been sustained. What should one do with intermittent blood pressure elevations, or systolic hypertension? With regard to the latter, it is necessary to admit our incompetence in dealing with high systolic pressure. This is caused by inelastic large "hardened" arteries and there is no known antidote. Reduction of cardiac output and lowering diastolic pressure may reduce systolic levels to a degree. However, there is no therapy specifically for systolic hypertension. This is not to say that elevated systolic pressure is not dangerous to the patient. Gubner has shown systolic pressure to be linearly related to patient mortality without regard to diastolic pressure.⁴ Occasionally, one may find a high systolic pressure in hyperthyroidism; treatment of this underlying disorder will correct the high output failure previously present and secondarily correct the systolic pressure.

Regarding the question of sustained *versus* labile hypertension, there is growing controversy as to whether labile hypertension is likely to become sustained. Therefore, one should carefully follow patients who have labile blood pressure elevation. Antihypertensive treatment of labile hypertension cannot be recommended at this point in time. Naturally, one must rule out

certain known causes of intermittent blood pressure elevation such as pheochromocytoma.

Hypertensive Work-Up

Over the years, it has been taken for granted that anyone with hypertension previously "not worked up" be cranked into an evaluation characterized by a variety of serologic studies (VMA, Catacholamines, Cortisol, electrolyte levels), radiologic procedures (rib films, hypertensive IVP, arteriography) and urologic studies (cystoscopy, split function studies). More recently, selective renal vein and plasma renin, and plasma angiotensin levels have been advocated. Most of these studies give negative results. Much time, energy, and money can be wasted.

It is important that the physician make a decision about his patient before embarking on a series of expensive, and sometimes difficult, uncomfortable tests. He must decide if he is going to surgically correct the patient's hypertension if a surgical lesion is found. Otherwise, there is little reason to perform the tests. In general, a good rule of thumb to follow is to base one's decision on age and duration of hypertension: patients over 45, or those whose elevated blood pressure has been present for a long time, usually do not warrant extensive evaluation.

With certain exceptions, one should go all out on the young hypertensive patient of recent onset for whom surgical therapy may produce a cure. Of particular interest are the differential renal vein renin studies which correlate best with surgical improvement when the level from the affected kidney is 2.5 times greater than the contralateral kidney. Renin determination, hypertensive IVPs, and renal arteriograms must be properly performed and carefully analyzed by someone proficient in these techniques.

Table 2

Highlights of Hypertensive Work-Up

History—Family History
Physical—Cardiovascular, fundoscopic examination
Lab—Cholesterol, Creatinine, Urinalysis, Plasma Renin, Electrolytes, 24-hour Urine for VMA and Catacholamines
Procedures, Chest X-ray, Hypertensive IVP, EKG
Special Studies—Renal Arteriogram, Differential Renal Vein Renins, Split function studies

Table 2 outlines the tests one may perform in evaluating a patient. If one anticipates no surgical intervention, the "special studies" may be omitted. Generally, one should screen serum electrolytes, creatinine, chest and rib films, EKG, VMA, and Catacholamines. If primary aldosteronism is suspected, salt loading tests can be per-

formed.⁵ Treatment of hypertension in older age groups should be instituted after this abbreviated work-up.

Hypertensive Therapy

How do we treat the hypertensive patient once the decision to start treatment is made?

There are many regimes in the current literature; it serves little purpose to enumerate another here. Of importance to the reader, however, is the emergence of a new drug that is useful in the treatment of hypertensive crisis that has recently been released for general use. Diazoxide (Hyperstat®) is a rapidly acting antihypertensive drug that has had promising results in trials conducted to date.⁶ The drug is a thiazide compound but, unlike most thiazides, causes sodium retention. The drug is given intravenously in a dose of 300 mg by intravenous push in less than 15 sec. Its mode of action is not known at this time but it appears that it may act directly on the vessel wall (vasodilator). If given as described, its action is swift, often normalizing the pressure within minutes. Hypotension does not occur. Repeated doses may be given.

When correction has been achieved, the patient should be started on an oral antihypertensive regime. While intravenous diazoxide may again be needed, one may actually gain control after one injection. Because of the sodium retentive property, diuretics are given parenterally along with diazoxide. An important side effect has been hyperglycemia. Therefore, close attention to blood sugar levels is indicated. Oral hypoglycemic agents are said to afford prompt control of this problem. Besides a prompt reduction in blood pressure, one obtains an increase in cardiac output and heart rate. Therefore, the drug must be chosen for those conditions where an increase in heart rate and cardiac output is not contraindicated. One such situation would be hypertensive crisis associated with a dissecting aneurysm. In this emergency situation, either antihypertensive medications that decrease cardiac output or surgery is indicated.

It must be emphasized that diazoxide has to be injected rapidly and in sufficient quantity to be effective. Finnerty has stated that this is explained by its binding properties. If the drug is given slowly, protein binding prevents the drug from its antihypertensive effect. If less than 300 mg is given or more than 15 sec is taken for this injection, only a brief effect is gained. If no response is achieved when given as directed, doses of 5 mg/kg may be used. Oral diazoxide may produce hyperglycemia and sodium retention, but

only mild decrease of blood pressure is obtained. Therefore, oral usage is not recommended. Lastly, it should be stressed that the drug is released for treatment of hypertensive crisis, not for treatment of nonemergency, mild hypertension.

An aspect of hypertensive therapy not usually covered in any length is the selection of drug to fit the condition. Alluded to in our discussion of aortic dissection, this selectivity is an important ingredient in one's choice of drug, or combination of drugs. As a further example, one must be cautious in prescribing a drug that increases heart rate in the face of tachycardia. Thus, hydralazine may be contraindicated in such situations. Furthermore, if two or more drugs are to be used, one should consider matching them according to mode of action and types of side effects. In general, do not use drugs that contain combinations in one pill. If one's titration of each compound results in a dose and schedule that matches such combination medications, then they may be appropriate.

Recent work by Laragh et al has provided us with hope that a more rational approach may be taken in the evaluation and treatment of patients with essential hypertension.⁷ His studies have shown that patients with this disorder fall into three groups with regard to plasma renin activity. Of the patients studied, 27% had low renin levels, 51% had normal levels, and 16% had high levels. The patients with low levels suffered no myocardial infarctions or strokes during his study, while the patients with normal and high levels had an incidence of 11% and 14% of one or the other of these complications.

While it is too early to draw conclusions, the potential significance is exciting in that renin determinations may give us a useful tool in determining which patients in this large pool require therapy. Conceptually, Laragh's findings may force us to modify the view implied earlier in this paper that all mild hypertensives may need therapy.

The best course of action for the physician to follow would be to treat essential hypertension as recommended earlier: Treat all patients with diastolics greater than 105 (possibly excluding certain older females) and treating those patients with diastolics between 90 and 105 according to the risk factors enumerated. Withholding therapy for those with low renins must await further study. It is not recommended that renin levels be ordered on all hypertensives at this time.

Summary

This paper has attempted to focus the reader's

attention on the intellectual framework that supports one's everyday handling of hypertension. The aim has been to redefine hypertension in terms of a quantitative distortion of normal rather than a qualitatively different disease. The need to be selective in working up patients has been discussed, and the desirability of choosing drugs on physiologic grounds has been stressed. Attention has been given to the use of diazoxide, and the recent work by Laragh on the relationship of renin to essential hypertension has been discussed.

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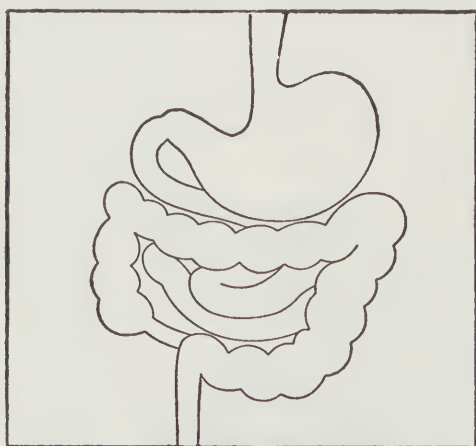
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NEIL SOLOMON MD PhD
Secretary

Maryland State department of health and mental hygiene

DEPARTMENT OF HEALTH AND MENTAL HYGIENE: DIRECTIONS FOR THE FUTURE

MATTHEW TAYBACK ScD
Assistant Secretary of Health,
Mental Hygiene, and Scientific Affairs

During the four years since a cabinet-level State Department of Health and Mental Hygiene was created, the philosophical and operating impetus of the Department has shifted from providing health care through categorical programs on a centralized, administratively convenient basis to a comprehensive, across-the-board approach of meeting the health needs of Marylanders with a minimum of inconvenience and fragmentation of services.

The thrust of the Department in the immediate future will focus on promoting self-sufficiency among the people and communities of Maryland. In line with this, Health Secretary Dr Neil Solomon has set as immediate service priorities: 1) services to the aged and chronically disabled, 2) services to troubled youth, and 3) programs to improve the environment. Accordingly, the Department will concentrate in the field of geriatric care on expanding the present levels of available care. Home care services, all day care facilities, and residential care within domiciliary care homes will be increased, and a more flexible capability will be sought in long-term care facilities which require intensive nursing. To coordinate these geriatric services and to ensure the most appropriate placement for the individual, screening and evaluation capabilities are proposed.

In the area of juvenile services, the Department is striving to minimize the institutionalization of youngsters in trouble with the law. As an alternative, these young people will be placed under the supervision of well-trained juvenile service officers, who will attempt to support

families in their efforts to provide a home for them. When youngsters cannot be placed at home and remain within their immediate communities, they will be given an opportunity for supporting daily life activities in group homes.

In respect to environmental problems, the major focus will be on the attainment of standards set forth by the Federal Government in connection with the air, water, and food.

Recognizing the changing focus of health care in Maryland, the 1973 Legislative Council requested from the Department a three-year plan, outlining the new programming, and projected costs that the Department proposes to implement.

To achieve the three-year objectives of 1) promoting self-sufficiency among individuals and communities, 2) increasing preventive health services to high-risk population groups, and 3) improving health planning and evaluation for accurate assessment of programs, the Department's plan calls for legislative approval of a \$151-million increase in the public health budget over the next three years.

The operating organization of ten administrations for program services will be continued during the next three years, and program budgets will be requested by each administration. Treatment approaches, services, and programs now will be designed, however, to deal with both the immediate and ancillary health-related problems of the individual.

If, for example, a retarded Marylander is

presented for treatment, the objective will be to provide a broad range of services including physical and mental evaluation, counseling, therapy, vocational training, medical care, dental care, recreational services, and educational programs available through the Mental Retardation Administration. Additionally, his family will receive guidance, counseling and instruction so that the retardate may return to as normal a living situation as he can handle. Coordinated support services will thus be provided not within the narrow confines of disease categories, but rather within a broader approach which stresses the optimization of functions of the individual regardless of his or her disability.

Aside from Medicaid, the largest budgetary increase requests in the three-year plan will be earmarked for new and expanded programming in the Mental Health, Mental Retardation, and Juvenile Services Administrations.

Mental Health Administration

More than \$13 million in additional monies have been projected by the Mental Health Administration as needed to 1) improve resources within the community, 2) provide joint hospital-community programs which will minimize the need for prolonged inpatient care and offer a needed continuum of treatment for patients within the community, 3) reduce the number of inappropriate admissions to psychiatric hospitals, and 4) upgrade the quality of care and rehabilitative programming in the hospitals.

In 1972 alone, more than half of the 16,000 persons committed to psychiatric institutions were admitted as alcoholics. These patients are more appropriately treated in quarterway and halfway houses, and in shelters. The Administration proposes to develop 60 such facilities during the next three years, which will accomplish the dual purpose of providing more effective treatment and reducing the number of inappropriate admissions to hospitals.

In keeping with the 1972 recommendations of the Humane Practices Commission, and in line with the basic principles of psychiatric medicine, the Administration is seeking to reduce the number of psychiatric residents in the hospitals to a maximum of 1,000 and to achieve a staff-patient ratio of 1:1. To accomplish this, alternate means of care and treatment must be located for a large number of patients.

The Administration's efforts to reach its goals include completion of the 250-bed Thomas Finnan State Hospital in 1976, expanded community health services programs, and completion of the 125-bed Inner City Community Mental Health Center in 1975.

Mental Retardation Administration

The Mental Retardation Administration proposes to spend an additional \$11 million over the next three years to provide new and expanded programs to increase the availability of regional and community-based care for the mentally retarded, and to decrease the population at Rosewood.

Presently, care for the retarded breaks down to 60% institutional and 40% community based. By 1976, that ratio is expected to change to 40-60.

Rosewood's population should be down to 1,700 by 1976 (with a goal of 500 by 1985). As smaller regional centers, day care centers, and group homes become available, those mentally retarded persons who can be most appropriately trained outside Rosewood will be returned to the community.

A 75% increase in the number of individuals participating in day care programs (an additional 1,345) and 44 additional group homes for 350 individuals are proposed over the next three years.

The regional center concept will expand as the second phase of Great Oaks Center and the Salisbury regional center becomes operational in 1974. The Administration also proposes to purchase or construct three additional regional centers to open sometime after 1976.

Juvenile Services Administration

The Juvenile Services Administration is now in the midst of a large-scale redirection in both philosophy and programming. The guiding precept is phasing down of state-wide institutions and placing increased emphasis on community programs.

The Administration is proposing to spend an additional \$6 million in new programs over the next three years designed to provide alternate methods of treatment in the community for nearly half of the 2,200 delinquent youths who are annually committed to juvenile institutions. Furthermore, action of the General Assembly which will go into effect on Jan 1, 1974 makes it illegal for a child who has been adjudicated in need of supervision (truant, ungovernable, runaway, etc) to be institutionalized. In 1972, nearly 1,300 such children were committed to training schools. When these children are brought to the attention of the juvenile court, adequate community-level programming and supervision also must be provided.

Purchase of residential care in community centers and private homes, increased day programs, and large-scale increases in counseling

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staffs to handle the anticipated increase in case-loads will take first priority, as will funding for full-scale evaluation, counseling, therapy, medical, dental, vocational, educational, and recreational services in the community programs.

The monies accrued from the proposed closing of Victor Cullen School and one half of the Maryland Training School for Boys will be used to purchase services in the communities for youths who are immediately affected by the closing of the institutions.

Aged and Chronically Ill Services Administration

In the 1974-1976 span, care and services for the aged will be directed to community-based treatment wherever possible, or will be provided in improved facilities designed to allow the elderly to live useful, fulfilling lives.

Historically, a great number of psychiatric admissions have been geriatric patients who were institutionalized because of inadequate alternative care facilities in their communities. Over the next three years, major priorities of the Administration are the establishment of geriatric evaluation units in every subdivision and region of the State, and assistance to communities to establish the needed group homes, foster homes, day care, home care, and outpatient clinic services to serve their elderly citizens.

The Department of Health and Mental Hygiene, during the next three years, proposes to convert special units at Spring Grove and Springfield hospitals into geriatric treatment facilities, and transfer these units to the Administration for the Aged and Chronically Ill. Similar units are planned at each of the State psychiatric hospitals to accommodate those patients now located in these hospitals who have no alternative means of care.

In the care of the chronically disabled, during the next three years, expanding outpatient and day care services, upgrading and expanding nursing services to meet recommended staffing patterns for chronic disease hospitals, and broadening the scope of rehabilitation programs are among programming priorities.

The Administration has also requested funding to study 1) the prevalence of various chronic diseases; 2) the availability of services and resources to prevent chronic diseases, including smoking withdrawal clinics, hypertension detection and follow-up, and saturated fat and cholesterol reduction; 3) the needed guidelines for adult disease prevention programs in various settings; and 4) present health programs in industry.

Environmental Health Administration

Environmental Health proposes to spend an additional \$1.3 million over the next three years to expand its programs in food and drug control, radiation protection, industrial hygiene, residential hygiene, water and sewage control, solid waste control, and air quality control.

In anticipation of increasingly stringent Federal and regional standards regarding air, water, and food quality, the Administration's programs are being geared to meet or surpass those requirements. The programming plans call for improving emission testing; expanding the monitoring of water pollution levels; and inspecting, monitoring and surveillance of existing water treatment facilities for the abatement of pollution sources.

Local Health and Professional Support Administration

This Administration proposes to spend more than \$4.5 million in new monies for new and expanded programs over the next three years.

The bulk of expenditures will go to assisting each local health department to provide those services needed to deliver comprehensive care to citizens in its area. The focus will be a three-pronged effort to increase preventive health services, expand community-based services as an alternative to hospitalization, and improve the quality of the environment.

Current plans call for increasing the health care services offered by each local health department, so that a full complement of clinics, home care services, and day care centers for the handicapped will be available to every citizen. Further, in anticipation of continuing rapid growth in all areas of the State, additional emphasis will be placed on environmental protection. Program proposals, in conjunction with the Environmental Health Administration's approach to the problem, will concentrate especially on waste and sewage disposal and food protection in each county.

Preventive Medicine Administration

In its role as technical and professional advisor, as well as the provider of some direct services to other component parts of the Department, the Preventive Medicine Administration proposes to expend over the next three years an additional \$2.5 million for expanding and implementing new programs in the areas of maternal and child health (day care and family planning), crippled children's services, veterinary medicine, dental health, communicable disease control, and disease screening.

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In its efforts to reduce infant and maternal mortality, the Administration will emphasize adolescent family planning programs, abortion referral, and research into adolescent pregnancy.

With its successful background in the development of services for crippled children, the Administration will undertake a new program of community-based services for the nonmentally retarded developmentally disabled.

Another major program area for the next three years is controlling the venereal disease epidemic.

Drug Abuse Administration

While the number of persons seeking treatment for heroin addiction is declining, thereby leading officials to deduce that hard drug abuse is presently on the decline, indications are that soft drug abuse is rapidly increasing. Over the next three years, then, the Drug Abuse Administration proposes to expend \$1.3 million in new monies for education, expanded treatment and rehabilitation services, and research.

During the next three years, the Administration aims to double the present number (4,000) of persons in treatment by providing funds to implement detoxification programs in local correctional institutions, by implementing an additional detoxification unit of 27 beds, and by realigning State funds for the Maryland subdivisions to accommodate the changing drug problem from hard to soft drugs and from urban to suburban locations.

Medical Care Program Administration

This Administration, the funding mechanism for health care for the indigent and medically indigent, accounts for nearly 50% of the total health budget. The rationale behind this program is not only to insure the adequate provision of health care for specific groups within the population, but also to insure, for a large segment of our elderly population, adequate health care, even through catastrophic illness.

The emphasis of the Administration is to reduce the costs of medical assistance which result from inappropriate or lengthy hospital stays, while simultaneously insuring reimbursements for outpatient and day treatment services.

Over the next three years, with the implementation of the Maryland Admissions Review Program (MARF), additional efforts will be directed to reviewing hospital use and limiting admissions and length of stay to what is medically justified.

Laboratories Administration

This Administration, which provides labora-

tory support for the personal health and environmental health problems of the Department, proposes to spend more than \$100,000 in additional monies during the next three years on new and expanded programs to provide more direct support to drug abuse and environmental health programs, State hospitals, and medical centers. Additionally the Administration proposes to establish standards and criteria of performance for physicians who perform their own laboratory tests.

Comprehensive Health Planning

The Comprehensive Health Planning Agency proposes an additional expenditure of \$150,000 over the next three years to expand the capability of manpower planning and certification of conformance review.

Concluding Comments

The initiative required in health services financed by public funds is, of course, highly dependent upon developments in the private sector and also by Federal initiative in connection with national health insurance. The State Department of Health and Mental Hygiene is currently involved in a substantial direct-service program for Maryland citizens, primarily in the area of long-term care. The objective in the future is to decrease such involvement in the day-to-day management of such care. It is recognized that there will be a continuous need for substantial effort in long-term care, but the objective is to encourage and obtain commitment on the part of local private, voluntary, and public agencies in the fulfillment of the direct service function.

Thus it is anticipated that in the area of personal health care the Department of Health and Mental Hygiene will seek to develop standards, to monitor the fulfillment of such standards, to manage public investments in personal health services, and to undertake responsible evaluation.

The immense concentration of funds on therapeutic services should not detract from an understanding that good health derives from the day-to-day practice by individuals of principles of hygiene. Such practices (good nutrition; avoidance of toxic agents such as alcohol, tobacco, and narcotics; and the adoption of life routines, including adequate exercise and attention to rest and recreation) require very little in the way of funds. To encourage Marylanders and all Americans in the pursuit of such objectives, the Department will look for opportunities of public health education.

Mary Louise Pierre

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by John Sargeant,
Executive Director

The Executive Committee met on Thursday, Aug 16, 1973 and took the following action:

1. Selected DeWitt E DeLawter MD, Bethesda, to serve as Chairman, Medical Advisory Board, Selective Service System, to replace John W Ashworth MD, Baltimore, who has left the state.
2. Nominated the following two physicians to serve on the Medical Advisory Board, Motor Vehicle Administration:
Harry A Spalt MD, Baltimore, Neurologist
Joel L Rosenthal MD, Hagerstown, Neurologist
3. Approved a contribution of \$200 towards the annual meeting of the American Association of Medical Assistants to be held in Washington DC, Oct 21-27.
4. Tabled a request for a \$25 membership contribution to the National House Staff Association for lack of information as to the aims and objectives of this group.
5. Changed Faculty policy with respect to payment of expenses of AMA Delegates, Alternates and the Faculty President for attendance at AMA House of Delegates sessions. The revised policy is: First Class rail or air fare transportation or mileage at appropriate rate (same as current policy) Single hotel room rate (same as current policy) \$35 per diem for meals, tips, and other transportation (up from \$20 per diem) Payment to be made for: Three Delegates, Two Senior Alternate Delegates, and Faculty President (deletion of third alternate delegate from payment of expenses)
6. Referred to the Subcommittee on Child Welfare a request that the Faculty revise its policy in connection with free distribution of syrup ipecac without a physician's prescription by druggists in Maryland. It recommended to the Subcommittee that favorable consideration be given to permit such distribution in one-ounce bottles, on request of the patient.
7. Approved publication of a Presidential Newsletter to be made on a regular basis, probably quarterly, in an effort to communicate more effectively with Faculty members.
8. Agreed, at the request of the Faculty's AMA Membership Committee, to invite chiefs of staff of all general hospitals in Maryland to the next meeting of component and specialty society presidents and secretaries set for Thursday, Sept 13, 1973.
9. Established meeting dates for the Executive Committee for 1974.
10. Authorized purchase of Medicare pamphlets, MEDICARE BENEFITS AND EXCLUSIONS, for use by physicians in Maryland. The Public Relations Committee plans to provide these to members for distribution in their office or by enclosure with their bills. They will have the Faculty name imprinted, as well as the American Society of Internal Medicine which developed and published the material originally. This expenditure will come from the amount allocated to the Public Relations Committee for its activities during the calendar year.
11. Approved a statement to be presented to a hearing on PSRO area designations scheduled for Aug 23, 1973, and authorized the Executive Director's attendance.
12. Offered a suggestion to the Woman's Auxiliary that a silver charm bracelet be an appropriate item for sale to celebrate their 25th anniversary in 1974.
13. Deferred action designating the Faculty's appointments to any statewide PSRO council until it can be learned who the new members of the Board of Directors of the Maryland Foundation for Health Care are.
14. Approved requesting representation on the Project Review Committee of the Regional Planning Council, and designated Alan C. Woods MD, Baltimore, to serve in this capacity if he will do so.

15. Approved approaching the State Insurance Commissioner to offer assistance in formulating any preamble or statement that may accompany publication of a list of fees charged by health providers. Recent legislation requires health insurance providers in Maryland to submit this data to the Commissioner for publication and availability to the public. It is to be made clear that the Faculty has some serious reservations regarding publication of this data.
16. Recommended appointment of J T H Johnson MD, Baltimore, to the Medical Relations Committee of Blue Shield to replace Jacob C Handelsman MD, Baltimore, who has resigned. Also selected Frank T Barranco MD, Baltimore, to serve on the Reference and Appeals Committee of Blue Shield.
17. Authorized submission of the following three names to the Secretary of Health and Mental Hygiene, one of whom will be selected to serve on the Noise Pollution Control Advisory Council:
 - Brook A Beyer MD, Rockville
 - Alvin C Wenger MD, Baltimore
 - James King MD, Cheverly
18. Learned that the proposed three-year plan of the Department of Health and Mental Hygiene had been broken down into categorical sections, all of which have been referred to appropriate Faculty committees for study, report, and action.
19. Agreed to cosponsor with the AMA, at an approximate cost of \$300, a workshop, Establishing Yourself in Medical Practice; date and location are still to be selected.
20. Referred to the Legislative Committee a recommendation that a Legislative Workshop be presented to which interested persons would be invited. The Workshop would provide information on the legislative process as well as educate physicians as to how to present a case before legislative committees of the General Assembly.
21. Authorized submission of the name of Liebe Diamond MD, Baltimore, to serve on a Parent/Interest Group of the Maryland Data System for the Handicapped, if she is willing to serve.
22. Approved submission of the following individuals to serve on an Advisory Committee on Methodology of Rate Setting, Health Services Cost Review Commission:
 - Hospital-based physician:
 - Emidio E Bianco, Baltimore, St Agnes Hospital
 - John H Mulholland MD, Baltimore, Union Memorial Hospital (alternate)
 - Non-Hospital-based physician:
 - Richard C Myers MD, Bethesda
 - Katherine H Borkovich MD, Baltimore (alternate)
23. Approved extending an invitation to guest speakers at the Faculty's Semiannual Meeting in Mexico City, and their wives, to attend scheduled social functions.
24. Approved expenditure of up to \$750 in 1974 for the 6th Annual Medical Aspects of Sports Seminar, such funds to come from the Educational Fund.
25. Adopted an amendment to the Retirement Trust Agreement for Faculty employees authorizing the trustees to designate investment counsel for funds held by the Trust.
26. Discussed the confidential nature of material discussed in various Faculty committees and authorized the President to write members of such committees to emphasize the necessity of keeping information (and, in particular, the names of physicians) on a confidential basis. It was also determined that all agendas and minutes will be stamped PERSONAL AND CONFIDENTIAL, continuously reemphasizing this point.
27. Designated Robert R Montgomery MD, Bethesda, to serve as Faculty representative on the Professional Practices Committee of the Maryland Hospital Association to replace Elmer G Linhardt MD, Annapolis, who has resigned.
28. Approved a meeting of the Executive Director with John J Kent, former Third District Delegate from Baltimore City, who has been named Assistant Secretary for Medicaid affairs in the Department of Health and Mental Hygiene.
29. Received for information and suggestions that the *American Medical News* is instituting a new column of "personal opinion" and is asking for names of "prominent" persons, both lay and physician, who would discuss "timely medical issues."
30. Approved payment of expenses of Harry F Klinefelter MD, Baltimore, to attend the Northeast Regional Conference on Quackery, in Philadelphia, if he finds it possible to attend.

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APRIL 17, 18, 19, 1974

Ample space is available; however, it is suggested that applications be submitted as soon as possible.

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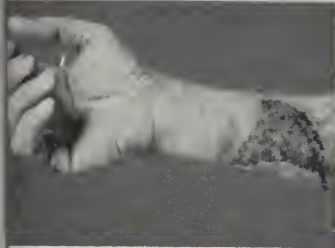
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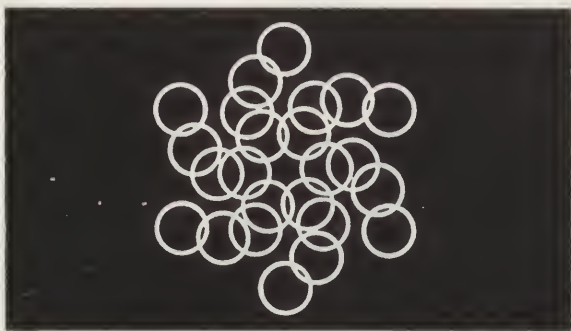
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alcoholism section

TRAINING PROFESSIONALS FOR MEETING THE NEEDS OF ALCOHOLICS AND PROBLEM DRINKERS

WILLEM G A BOSMA MD

Dr Bosma is Director, Alcoholism and Drug Abuse Programs, University of Maryland Medical School, Baltimore.

Introduction

Until recently, most mental health clinics treated alcoholics side by side with other disturbed people, often without cognizance of their alcoholic dependence. No special facilities or personnel were available to the alcoholic, even though he seemed to benefit little from conventional mental health treatment modalities. The alcoholic cannot be effectively treated if his condition is not diagnosed correctly.

In the last decade, strides have been made in recognizing alcoholism as a massive health problem. Alcoholism has been declared a disease. States have allocated funds to set up treatment facilities, and so on. It is, however, almost a truism to suggest that there has been very little actual change. Members of the helping professions are still often reluctant or unable to respond to the alcoholic.

In the history of almost every alcoholic, even today, are accounts of periodic searches for help, of desperate appeals to physicians, hospitals, clergyman, teachers, and others—and of meeting with confusion, rejection, and ignorance.

In the meantime, alcoholism and alcohol-related problems have increased in our society.

There are two major challenges to the people concerned with alcoholism today. The first is education which encompasses not only enlightening the public about the alcoholic, but also training professionals and paraprofessionals in diagnosing and treating the alcoholic. The second is setting up adequate innovative and comprehensive treatment facilities.

Reprinted with permission from Proceedings: On Alcoholism Emergency Care Services, National Institute of Mental Health, National Institute on Alcohol Abuse and Alcoholism, Rockville Md, 1972 issue.

Maryland Alcoholism Programs

I have been associated with the University of Maryland for almost two years as Director of Alcoholism and Drug Programs. It is the services and educational efforts at that institution that I will attempt to delineate here.

First, however, it is necessary to put the program at the University of Maryland into the context of Maryland state policy on alcoholism.

Through the outstanding leadership and perseverance of the staff of the Division of Alcoholism Control of the State Department of Mental Hygiene, not only did Maryland enact the first comprehensive alcoholism law (1968), but has also gone far in developing statewide comprehensive services.

The basic premise of the law is that alcoholism is a massive community problem. Therefore, alcoholism programming must emphasize decentralized local, community service and de-emphasize State control and institutionalization. State hospitals and jails have never been equipped, nor should they be required, to handle alcoholics. Alcoholics can and should be treated in the mainstream of health and social welfare agencies; specialized services should be limited to those not already provided by existing health and social services.

UM Hospital Program

Following are the services for alcoholics provided for the last two years in Baltimore at the University Hospital, an example of an existing health facility pressed into the service of pro-

viding treatment for alcoholics. This is a 600-bed service facility and also a teaching hospital associated with the University of Maryland. Patients come from all walks of life; being located in the inner city, the hospital primarily serves a so-called poverty area. Thus, it tends to get a great many Skid Row alcoholics. The alcoholic is met in the Emergency Room by a counselor who acts as a screening agent. Together with the doctor on call, he decides where the patient will go for treatment. Some need to go to medical, surgical, psychiatric, or other specialized service. Wherever he goes, there will be an alcoholism counselor on duty.

If the patient does not require any service within the hospital and has no home, he or she can be referred to the quarterway houses. These residential facilities are two blocks away from the hospital and all the services of the hospital are available to it. Doctors make weekly rounds in this 30-bed facility for men and 10-bed facility for women.

If the patient requires detoxification, it begins in the Emergency Room and is completed in the quarterway house. If necessary, he is made comfortable with tranquilizers, good food, and so on. He becomes involved immediately in a program of education, personal and group counseling, therapy, and vocational rehabilitation.

The quarterway house is a recent development. The facility for men, the Tuerk House, was started two years ago and the house for women in Feb 1972. Dictated by need and financial realities, the staff is constantly experimenting with new ideas and methods of treatment.

An hour's lecture is delivered by a counselor in the morning. He uses material developed in recent years and other pertinent material, as well as slides, charts, and films. In the afternoon, there is a discussion of the morning lecture. Besides this, the men attend at least one group

therapy session or AA meeting a day, while the counselor sees them in hourly individual sessions on the second, sixth, and tenth day of his customary two-week stay.

The lectures and discussion are repeated on a weekly basis, since the patients were often confused and unable to understand much for up to a week after detoxification. Families and relatives are involved in the treatment program as much as possible. The pros and cons of disulfiram, which many choose as an adjunct to therapy, are discussed.

After two weeks, the patient is referred to the Outpatient Clinic at University Hospital and, if he is on disulfiram, to the Antabuse Group which meets weekly in the quarterway house. Two alcoholism counselors make regular home visits and help the patient avail himself of treatment facilities in his neighborhood.

If the patient is well enough after having been seen in the Emergency Room, where he sometimes stays up to 24 hours, he can be sent home. From there, an effort is made to involve him in various treatment facilities in his neighborhood, such as open or closed groups, outpatient psychiatric services, personal counseling, aftercare clinics, etc.

If a man has nowhere to go, he can be referred to the Shelter, a 50-bed facility. The Shelter takes Skid Row alcoholics and provides them with beds, meals, and some counseling. They are not required to stop drinking, but it does seem to reduce the amount they drink and a few, in fact, stop drinking entirely.

This facility for what we call the "chronic alcoholic" is a helpful one. Previously, the chronic alcoholic had been referred to other agencies, where the assumption was that he would stop drinking. Neither party benefited from this arrangement, as this rather hopeless

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patient tended to "clog up" facilities needed for patients with better prospects.

The two halfway houses associated with our program are for recovering alcoholics with job possibilities who need an interim supportive environment until they are able to go out on their own.

Staff Requirements

In University Hospital, all major inpatient services have an assigned alcoholism counselor. Patients are referred by the doctors for counseling. When the patient leaves the hospital, he is referred to any of the described services.

In addition, there are various open and closed groups available to anyone interested. These groups are run by the counselors; the hospital chaplain; some residents in psychiatry, neurology, and medicine; and by the director of Alcoholism Services. AA group meetings and meetings for relatives are also held in the hospital.

These services are carried out by a physician director (also responsible for the drug abuse program and the educational program), a nurse coordinator, a full-time nurse for the two quarterway houses, and 20 counselors. At the center of the treatment program is the paraprofessional: the alcoholism counselor. A significant number are recovering alcoholics, but most have had little or no background in the treatment of alcoholics. Their level of education and social background is very disparate.

It is difficult to delineate the ideal alcoholism counselor. First and foremost, the individual must be aware of the problems of alcoholism and believe that the alcoholic can be helped. He must be nonjudgmental, sympathetic, and empathetic. None of these characteristics can be truly determined in an interview. The final test comes on the job or, as the director of one of the quarterway houses puts it: "You can only tell when you work with them." Some alcoholism counselors are more effective than others, with no regard to previous education or experience.

Alcoholism counselors at University Hospital have all been trained by the Baltimore City Health Department, which gives a six-month training course. Training such a disparate group of people is a major undertaking, since care must be taken that the slow learners and less-educated trainees receive sufficient background material and individual attention while, at the same time, providing a challenge to the persons

who can absorb the material more quickly. Classroom instruction includes lectures, discussions, questions and answers, role playing, and guest speakers. Field trips to existing alcoholic treatment facilities are made and the programs evaluated. There is continuing inservice training for the counselor. Since the counselors are trained in all areas of alcoholism treatment, from taking case and family histories to having learned basic counseling skills, they are the backbone of the treatment programs; the professionals involved in University Hospital's alcoholism services serve mainly as consultants and teachers.

Detoxification Services

There is one service our program sadly lacks: a separate detoxification unit. At the beginning, it was felt that such a unit was not necessary, since the Emergency Room and the quarterway house could be used. This has not proven to be feasible.

The Emergency Room is always crowded. Using the waiting room or the available beds to detoxify a patient has frustrated and angered the Emergency Room personnel to the point that the alcoholic is now confined to a "holding area" until he can be transferred to another facility. Actually, very few (313 of 4,280 visits in 1971 or approximately 8%) were in need of emergency medical care. Yet 90% of the admissions were in need of detoxification. It is unfair to expect a very positive attitude by the Emergency Room personnel in these circumstances. The quarterway house is not much better equipped to detoxify the alcoholic. It is now clear that this is a burden its personnel should not have to carry either.

Hopefully, the hospital will see fit to provide a walk-in detoxification unit in the near future. The projected detoxification and holding unit would have a capacity of 20 beds. Medical coverage will be given by a physician on a half-time basis, while full-time emergency coverage will be available through the medical services of the hospital (residents and interns). The basic care will be given by the full-time coverage of one nurse, one hospital attendant, and one alcoholism counselor. The first two will be responsible for starting the complex rehabilitation process and referring the patient to the comprehensive services and treatment modalities available after detoxification. Of course, administrative and clinical services will be part of the unit.

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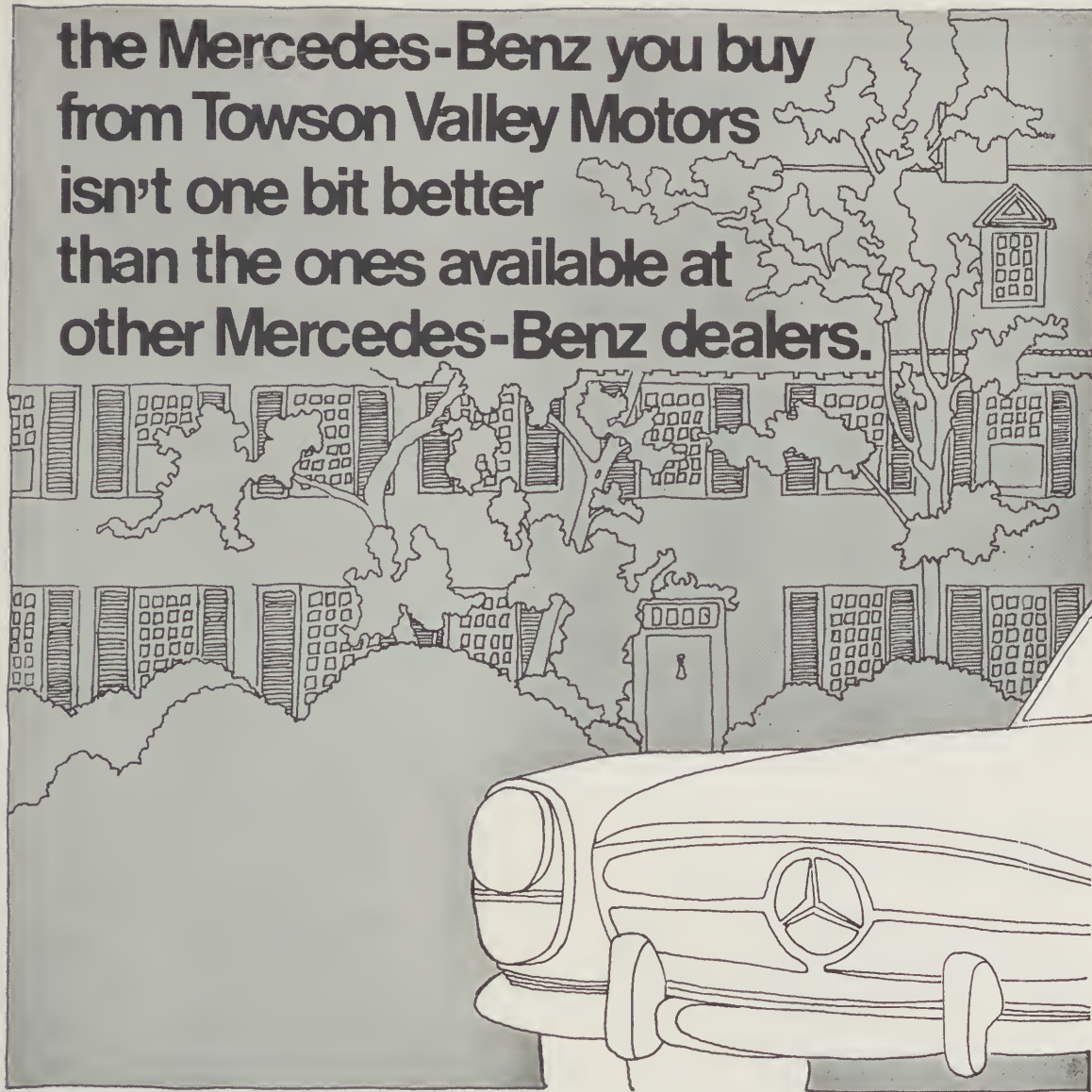
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

NOVEMBER 1973

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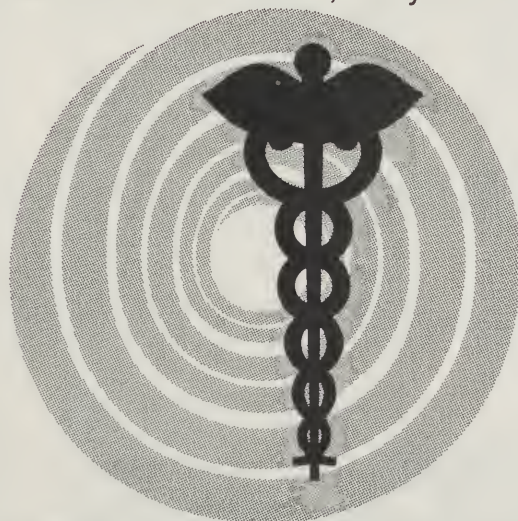
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COVER — Aerial view of Baltimore City Hospitals, 4940 Eastern Ave, Baltimore, which celebrates its 200th Anniversary this month. A hearty Med-Chi salute as you embark on your third century of service!



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acute arthritic inflammation...heat that freezes

In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

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Tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

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More than sleep.

your choice of sleep medication
is wisely based on more than
sleep-inducing potential

sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hours
without need to
repeat dosage

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

leep with
consistency

Dalmane (flurazepam HCl) is a distinctive sleep medication—a zodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other sedative hypnotic.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, non-habit-forming agent proved effective and relatively safe for relief of insomnia.

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

DALMANE[®]

(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



ROCHE LABORATORIES
Div., Hoffmann-La Roche Inc.
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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

**These professional and trade organizations are united
in supporting ant substitution statutes and regulations:**

The American Academy of Dermatology

The Board of Directors of the
American Academy of Family
Physicians

The Executive Board of the
American Academy of Neurology

The Committee on Drugs of the
American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the
American College of Obstetricians
and Gynecologists

The Board of Regents of the
American College of Physicians

The Board of Trustees of the
American Dental Association

The Board of Trustees of the
American Medical Association

The American Psychiatric Association

The Executive Committee of the
National Association of Retail
Druggists

The Board of Directors of the
Pharmaceutical Manufacturers
Association

The National Wholesale Druggists'
Association



Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that

economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

*Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005*



**ROCHE announces
new**

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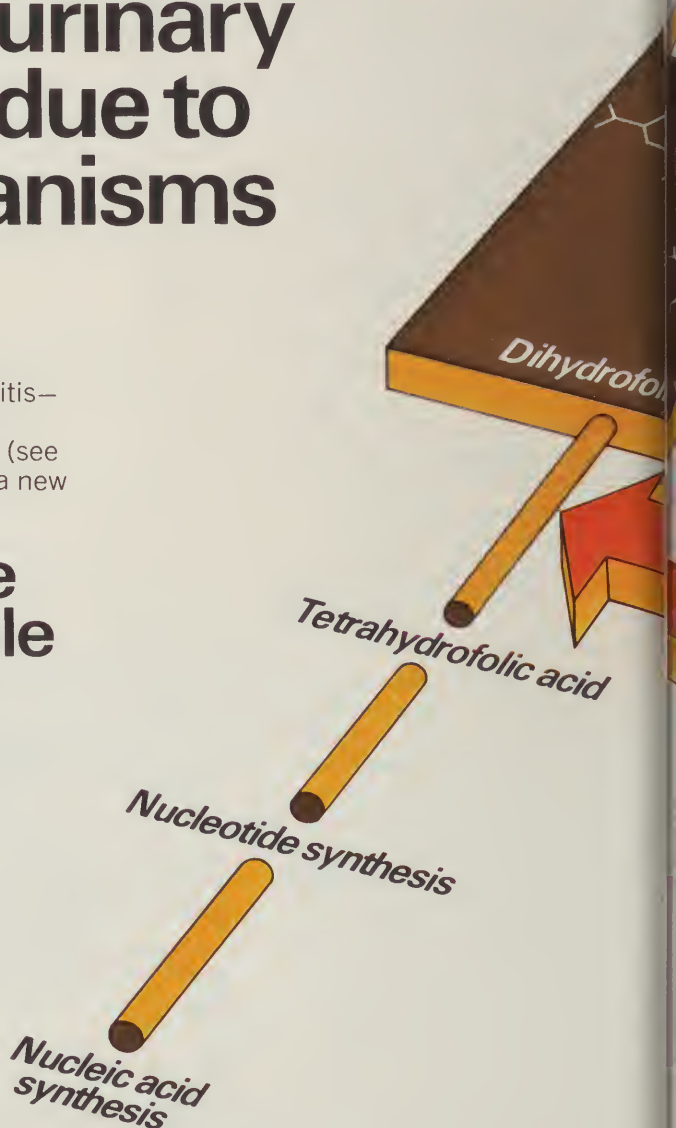
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

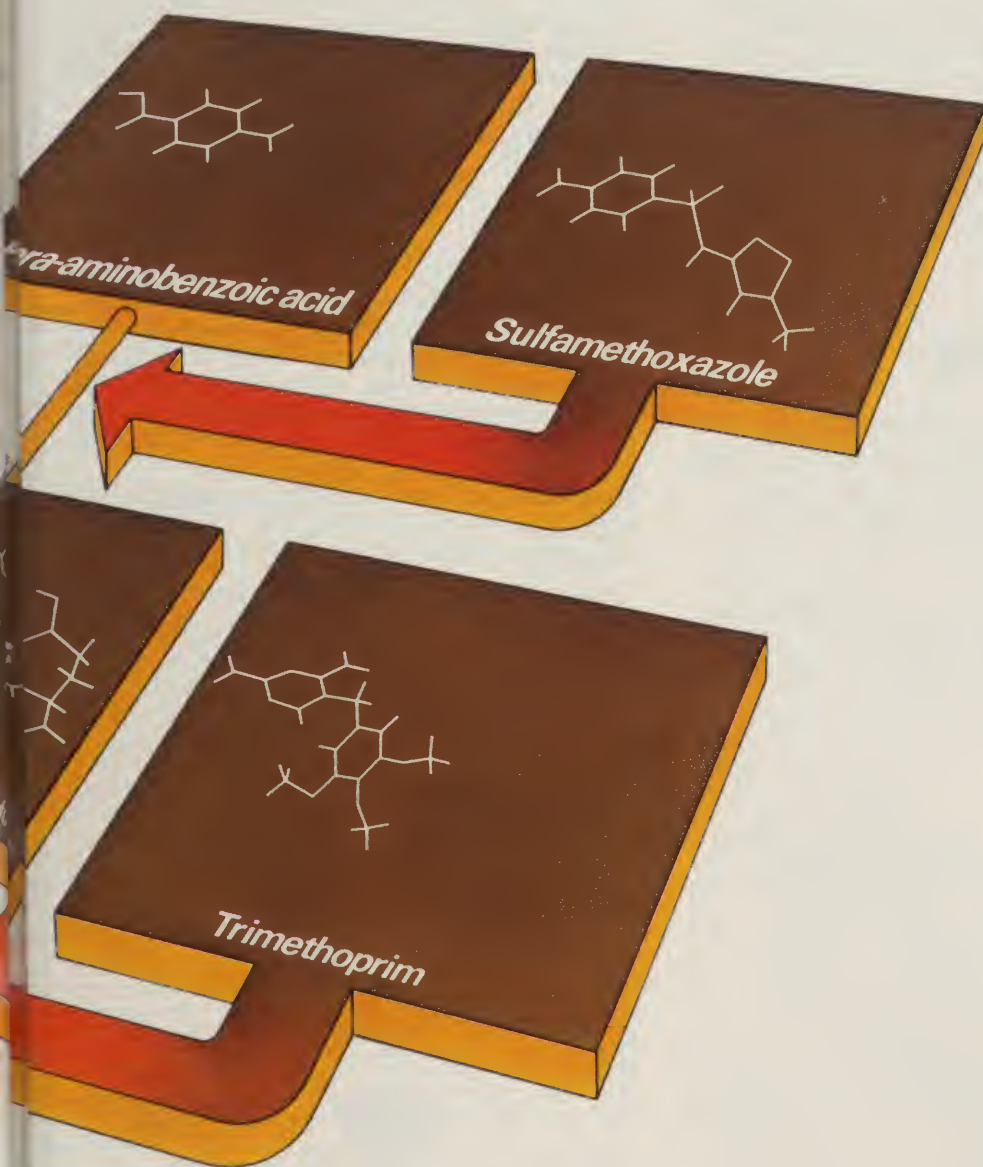
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





new **BACTRIM**TM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471[†] patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

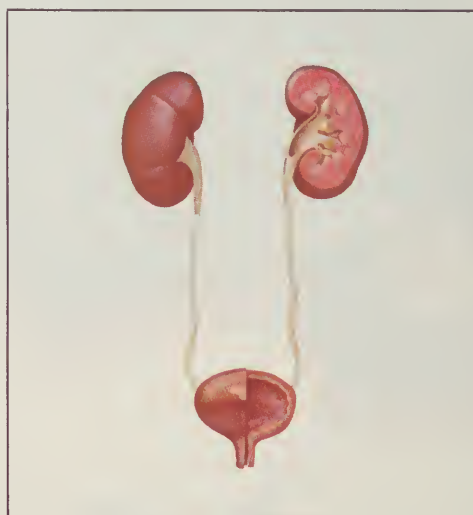
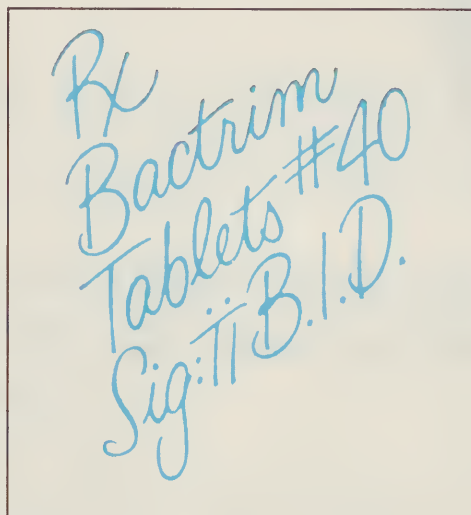
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

[†]4 patients not available for evaluation at day 10.



new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is *N*-(5-methyl-3-isoxazolyl)sulfanilamide. It is a almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: Microbiology: Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP SMX	
<i>Escherichia coli</i>	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
<i>Proteus</i> spp.	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Indole positive <i>Proteus</i>	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
<i>Mirabilis</i>	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5
<i>Klebsiella-Enterobacter</i>				

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than the concentrations in the blood. When administered together in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Important note: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Doctors in the News



Dr Zieve

Philip D Zieve MD has been appointed Chief of Medicine at Baltimore City Hospitals.

The Baltimore native received his premed education at Franklin and Marshall College and his MD from the University of Maryland Medical School.

He chose City Hospitals for his internship in Medicine and remained for two years as an Assistant Resident.

After a two-year absence as a Fellow in Medicine and Hematology at the Johns Hopkins Hospital and one year as Chief Resident in Medicine at Sinai Hospital in Baltimore, Dr Zieve rejoined City Hospitals' staff as an Assistant Chief of Medicine.

He has also served as Associate Chief of Medicine and Chief of Hematology.

Additionally, Dr Zieve is an Associate Professor of Medicine at the Johns Hopkins School of Medicine.

The Johns Hopkins University Board of Trustees has appointed **A McGhee Harvey MD**, former Chairman of the Department of Medicine, as the University's first Distinguished Service Professor.

The Board created the new title last spring to give recognition to faculty members who have made outstanding contributions to the administration of the University.

President **Steven Muller MD** said: "Dr Harvey's achievement is measured by the outstanding record of the Department of Medicine and the careers of the hundreds of doctors and scientists who received their training under his auspices and inspiration."

Dr Harvey stepped down recently as Chairman of the Department of Medicine and Physician-in-Chief at the Johns Hopkins Hospital to resume his full-time professorship and research.

Henry M Seidel MD has been appointed Associate Dean for the School of Health Services, Johns Hopkins University.

Dr Seidel's duties will include academic program development at the new School; the first students were admitted in September.

Until his recent appointment, Dr Seidel had been Director of Clinical Programs, Columbia Medical Plans, Columbia Md.

Howard F Raskin MD has been appointed head of the newly formed Division of Gastroenterology at the Maryland General Hospital in Baltimore.

Dr Raskin comes to MGH from the University of Maryland Hospital where, for 11 years, he headed the Division of Gastroenterology. The gastroenterology laboratory he helped develop while there is

relocating at MGH. His laboratory has received worldwide recognition in the treatment and study of diseases of the gastrointestinal tract.

Melvin L Keller MD has been appointed Medical Director of the Intensive Care Unit at Baltimore's Sinai Hospital.

Dr Keller, an attending anesthesiologist, also is responsible for the surveillance, resuscitation, and basic life support of all patients in ICU. He also supervises the training and continuing education program for ICU personnel, including interns and residents.

Three Maryland physicians will receive research grants during the 1973-74 fiscal year from the American Heart Association.

They include **Herbert Dickerman MD**, **Giraud V Foster MD**, and **Helen B Taussig MD**.

The studies will be conducted at Johns Hopkins.

Stephen J Ryan Jr MD, Associate Professor of Ophthalmology at the Johns Hopkins University, has been awarded the Louis B Mayer Scholars Award by Research to Prevent Blindness Inc, to continue his research on macular diseases, the most common cause of loss of useful vision.

Dr Ryan is the third recipient of the prestigious \$25,000 award. The grant will support and provide a special incentive to his research on macular degeneration.

Samuel P Asper MD, Vice President for Medical Affairs at the Johns Hopkins Hospital, has been named Dean of the Medical School of the American University of Beirut and Chief of Staff of the American University Hospital in Lebanon. Additionally, Dr Asper will hold the academic post of Professor of Internal Medicine.

Dr Asper, a graduate of Baylor University, has been associated with medicine at the Hopkins throughout his career, which began in 1940.

Leonard H Golombek MD is the newly elected President of the Baltimore County General Hospital Medical Staff.

Other new officers include **George H Greenstein MD**, Vice President; **Arnold H Michael MD**, Secretary; and **H Gerald Oster MD**, Treasurer.

Arthur Baitch MD, immediate past president, will serve as medical staff representative on the hospital's Board of Trustees.

Among those reappointed to three-year terms on the Baltimore County Mental Health Advisory Committee are **Margaret L Sherrard MD**, Deputy Director of the Baltimore County Department of Health; and **Robert W Gibson MD**, Medical Director, Sheppard-Pratt Hospital.

Edward S Stafford MD, Associate Dean of the Johns Hopkins University School of Medicine and Professor Emeritus of Surgery, has been named Acting Director of Clinical Programs for the Columbia (Md) Medical Pan.

We were in error in reporting, in the September Journal, Dr Russell S Fisher as being the first Maryland representative on the AMA Council on Medical Education.

Our apologies to **Warde B Allan MD** and **Harvey B Stone MD**, both of Baltimore City, who served for some ten years in an earlier era, Dr Stone as Vice Chairman.



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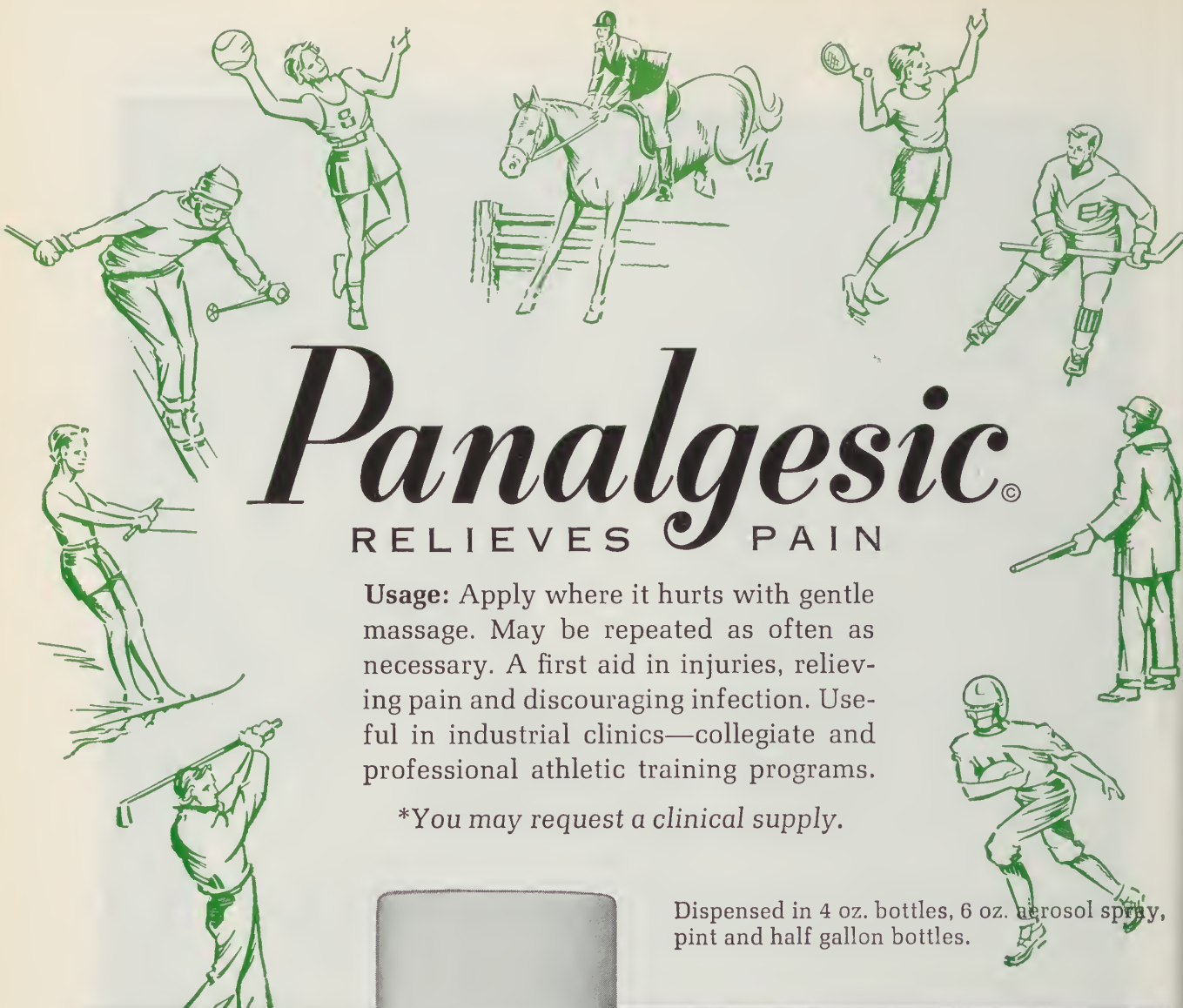
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Medical Miscellany

Medical Series Debuts on PBS-TV Nov 19

Nov 19 marks the premiere of an important series of five TV programs to be presented on Public Broadcasting stations across the country every Monday evening.

The subjects: Heart Disease, Nov 19; Inborn Genetic Defects, Dec 17; Pulmonary Disease, Jan 14; Trauma, Feb 11; and Cancer, March 11.

Designed to inform the public about methods of prevention, early detection and treatment of the five medical conditions that account for three out of four deaths in the United States, it is also planned as a springboard for community action. Many of the PBS stations will schedule additional local programming by featuring local medical leaders and community follow-up action.

Mental Hospitals Admissions

The Maryland State Department of Mental Health and Hygiene has placed new regulations in effect Oct 1 to govern involuntary admissions to mental health facilities under their jurisdiction.

Dr Neil Solomon, Secretary of Health and Mental Hygiene, says the regulations provide broad new safeguards to ensure that no person is denied due process of law.

Under the new regulations, a person involuntarily committed is first placed in an Observation Period status, during which he has the right to consult with his family, legal counsel, and a physician or psychiatrist of his own choosing.

Within 24 hours, he must be notified in writing of the date, time, and place of a hearing to be held regarding his admission status and have the opportunity to be examined by a psychiatrist. The hearing itself must be held within five working days of the date of his admission.

In addition, the patient shall not be required to take medication which will substantially adversely impair his ability to participate fully in his hearing and his records shall be maintained

separately from the ordinary patient records of the hospital.

"We have written the regulations," Dr Solomon said, "to ensure that any person being considered for involuntary admission to a mental health facility will have the rightful benefit and opportunity of having the facts of his case fully reviewed and evaluated, to make sure that no one is detained improperly. This is an additional safeguard which will augment legal protections guaranteeing any person confined against his will the right of habeas corpus and judicial release."

Under provisions of Maryland law, persons may be admitted to State mental institutions against their will upon certification of two physicians that the person is suffering from a mental disorder, in need of care or treatment and presents a danger to either his own life or safety, or the life of others.

Clinical Center Study

The Molecular Hematology Branch of the National Heart and Lung Institute is engaged in an extensive program of research designed to understand erythroid differentiation and hemoglobin biosynthesis.

Of particular interest in these NIH studies at Bethesda Md are patients with disorders of hemoglobin structure and synthesis including thalassemia, sickle cell anemia, and other hemoglobinopathies. Patients with refractory anemia, polycythemia, or chronic DiGuglielmo's syndrome are also of special interest.

Physicians interested in having their patients considered for these studies may write or phone Dr Arthur W Nienhuis, Chief, Clinical Services, Molecular Hematology Branch, Clinical Center, Room 7D20, National Institutes of Health, Bethesda Md 20014, (301) 496-3684.

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Burkitt's Lymphoma

The cooperation of physicians is requested in the referral of patients with the histological or cytological diagnosis of Burkitt's lymphoma for studies being conducted by the Pediatric Oncology Branch of the National Cancer Institute.

Patients should be less than 20 years of age and have a suspected or proven diagnosis of undifferentiated malignant lymphoma.

Patients previously treated or patients in relapse will be considered for admission, but previously untreated patients are preferred.

Physicians interested in having their patients considered for admission should contact Dr John L Ziegler, Chief, Pediatric Oncology Branch, Clinical Center, Room 3B-14, National Cancer Institute, Bethesda Md 20014, (301) 496-4256.

Pediatric Residency Program

The Residency Review Committee for Pediatrics of the AMA, representing the American Academy of Pediatrics, the American Board of Pediatrics, and the AMA's Council on Medical Education has granted approval to the pediatric residency training program of St Agnes Hospital (Baltimore) for a Group I program.

According to Dr Frederick J Heldrich, Chairman, Department of Pediatrics, St Agnes, the program will enable physicians trained in pediatrics at St Agnes to apply for examination by the American Board of Pediatricians.

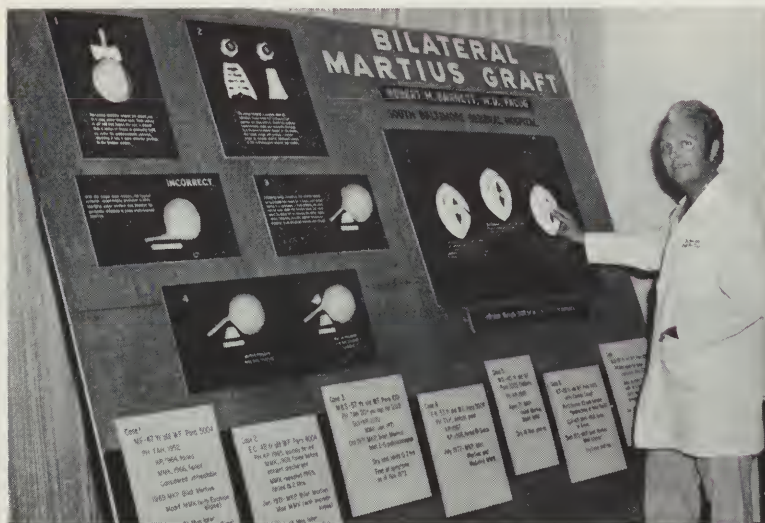
"Approval of the program is an indication of the steadily increasing size and activity of the department's 51-bed pediatric unit; it also allows us to increase our residency staffing in the 60-bassinet unit for newborns," Dr Heldrich reports.

Dr Heldrich concluded: "Approval reflects the superb effort and cooperation of hospital administration and the pediatric attending staff in the development of the pediatric residency training program at St Agnes Hospital."

PSRO Organization

Twenty-seven state medical societies preferred the establishment of statewide umbrella PSRO organizations, in a survey of the activities and attitudes of state medical societies on PSRO, conducted by the AMA's Center for Health Services Research and Development. The survey was sent to the 51 constituent societies and the response rate was 100%.

Only seven states do not currently anticipate seeking PSRO status. Twenty-seven states have submitted letters of intent or supported an application for designation of a state-level organization as a PSRO. In addition, 16 states said they plan to support an application, while one was undecided. Survey reports are available from Center for Health Services Research and Development, AMA Headquarters, 535 N Dearborn St, Chicago Ill 60610.



DISPLAY—Robert M Barnett MD, Director of Ob-Gyn at South Baltimore General Hospital, points to "Bilateral" Martius Graft, on display in the Physicians' Lounge. Originally prepared for the annual meeting of the American College of Ob-Gyn, the display was part of a presentation highlighting what Dr Barnett refers to as "An old procedure with a new use—used to successfully manage the problem of previous surgical failure to correct female urinary incontinence."



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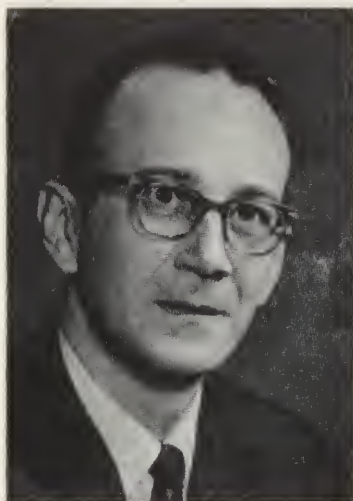
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Dr Antlitz

At the 1973 Annual Meeting, several Faculty members were elected to assume office at the conclusion of the 1974 Annual Meeting.

To better acquaint Med-Chi members with these officers, short biographies and photos of each will be published in the *Maryland State Medical Journal* in the coming months, as has been done in the past.

The series begins with Albert M Antlitz MD, scheduled to become a Central District Councilor immediately after the 1974 meeting.

The Baltimore native was born Aug 15, 1929.

His college education was received at nearby Georgetown University in Washington where he received his BS in 1951 and his MD (cum laude) in 1955.

An internship at Baltimore's Mercy Hospital preceded a 1956-1958 stint with the Armed Forces where he served as a Captain, US Army Medical Corps, 101st Airborne Division.

From 1958 to 1960 he was an Assistant Resident in Medicine at University Hospital in Baltimore. And

Meet Your New Council Members

from 1960 to 1962 he had a USPHS Fellowship in Cardiology in the Department of Medicine at University Hospital.

Since 1962 he has been in the private practice of Cardiology, with offices located in Mercy Hospital.

Dr Antlitz received his certification from the American Board of Internal Medicine in 1963 and from the Cardiovascular Subspecialty Board in 1972.

His academic appointments include these four:

Head, Division of Cardiology and Department of Electrocardiography, Mercy Hospital;

Director, Coronary Intensive Care Unit, Mercy Hospital (1967);

Director, Intensive Care Unit, Mercy Hospital, (1969); and

Assistant Professor in Medicine, University of Maryland School of Medicine.

Dr Antlitz enjoys staff privileges at Mercy, Saint Joseph, and University hospitals, and serves as Consultant in Cardiology at the Perry Point VA Hospital.

He holds the title of Fellow in the American College of Cardiology, Council on Clinical Cardiology of the American Heart Association, American College of Physicians, and American College of Chest Physicians.

In addition to AMA, Med-Chi, and Baltimore City Medical Society memberships, he has memberships in the New York Academy of Sciences, and the American Heart Association.

Dr Antlitz is currently

serving as Chairman of the Faculty Committee on Joint Practices. He was 1972-1973 Chairman of the Committee on Program and Arrangements, receiving copious praise for the highly successful 1973 Annual Meeting.

He also serves on the Membership Committee of the Baltimore City Medical Society.

His wife, Carolyn, is Treasurer and a member of the Board of the Women's Auxiliary at Mercy Hospital. They have six children (four girls, two boys).

As his chief means of relaxation, Dr Antlitz enjoys boating on the Chesapeake Bay as often as his busy schedule will permit.

Medicare Reports

Medicare investigative reports completed after Jan 31 will be made public, the Social Security Administration announced. They include reports on deficiencies in institutions, home health agencies, and independent laboratories, as well as evaluations of carriers, intermediaries, state agencies, and providers.

The names of physicians found to have furnished excessive services will be released only "after consultation with a professional medical association" or a state medical authority and after the physician has had an opportunity to offer evidence.

These points on physicians were not contained in the regulation when it was proposed last September. They apparently were added in response to criticism from the AMA and others.



ROBERT E FARBER MD MPH
Commissioner

Baltimore City health department

Mobile Dental Clinics

The city's six Model Cities mobile dental clinics will continue in operation during the winter months under the general supervision of Dr H Berton McCauley, Director of Dental Care in the Baltimore City Health Department.

Each of the six vehicles has two dental operatories and a staff of two including a dentist and a dental assistant. Designed to provide comprehensive dental services for Model Cities residents, the mobile dental facilities are located here:

Model Cities Council Area A—601 N Central Ave in front of Public School #102

Council Area B—1100 Valley St at School #16

Council Area D—2211 Linden Ave at School #61

Council Area E—1401 W Lafayette Ave at School #35

Council Area F—601 Brune St at School #30

Council Area G—1400 W Lexington St at School #95

While school children are seen on a priority basis, physicians are advised that adults may obtain care for themselves or younger children in their family by registering with the neighborhood Model Cities Council office.

The first Model Cities mobile dental clinic began operation under Health Department supervision in November 1971, the last two in January of this year. During the year and six months since the first vehicle was acquired, 2,287 adults and 3,601 children received 5,800 prophylactic treatments, the benefits of 2,682 decay-damaged teeth restored, and 2,217 infected teeth removed. Approximately 500 dentures and prosthetic appliances were constructed, mostly for adults. In a related educational program, 55,000 children attending school in Model Cities areas received

the benefits of a self-applied topical fluoride to reduce decay susceptibility.

Physicians and Model Cities residents may obtain additional information from their neighborhood Council Area office.

Nutrition for Elderly

"Eating Together In Baltimore," a nutrition program for Baltimore's older adults, is the city's latest attack on malnutrition in the elderly. Administered by the City Health Department's Division of Nutrition under the direction of Mrs Eleanor McKnight Snyder and inaugurated early in August, the program is made possible by a \$65,000 grant from Title III funds of the Older Americans Act through the Maryland Commission for the Aging, a sum which will be expanded to \$107,000 with matching in-kind services.

Specifically, the project will provide sites for group meals in specific areas of Baltimore City where large numbers of older persons are now living. At these sites, about 150 meals a day will be provided by a food service company five days a week, and individuals over 60 years of age will be able to meet with others their age in a friendly, homelike atmosphere. The meals will provide one third of daily nutritional needs of older persons as well as offer a means to overcome loneliness which is often the lot of the elderly.

Established as a demonstration project, sites for the initial program have been selected in areas where other programs for the elderly are already in operation. In McCulloh Homes, 1102 Druid Hill Ave, the nutrition program will be coordinated with a City Department of Recreation Senior Center in a housing complex for the elderly. A second site will be the Midtown Senior Citizens Center in St Mark's Church at St Paul and 20th Sts located near a new housing development for aging persons where the Recre-

ation Department is also offering some programs. The third site is the former SAGA—Model Cities Day Care Center at 1401 Battery Ave, now the South Baltimore Senior Center. Here, under reorganization by a Citizens Advisory Committee, a variety of community groups, the Mercy-Southern Health District facility, and another Department of Recreation program will work in conjunction with the new nutrition program.

"Eating Together In Baltimore" was developed by the Mayor's Advisory Committee for Nutrition Programs consisting of members of interested public and private agencies convened in July of 1972 to plan for Title VII of the Older Americans Act which will enable further expansion of this program. The Committee's purpose was to develop plans that would assure that Baltimore City would receive full benefit of this new federally-funded nutrition program.

Agency representatives who form a professional advisory committee for Mrs Snyder, the Project Director, include Mrs Selma Gross, Executive Director, Commission on Aging and Retirement Education; Mr Joseph Obey, Social Service Coordinator, Model Cities Agency; Miss Olive Caulk, Consultant for the Elderly, Department of Housing and Community Development; Mr Stewart Davis, Chief, Multipurpose Center Planning, Department of Planning; Mrs Sylvia Fox, Director, Senior Citizens Program, Department of Recreation; Mr Orville Swafford, Assistant Director, Special Home Services, BCHD; Mr Abraham Shecter, Principal Sanitarian, Bureau of Food Control, BCHD; Rev Don Bruce Lowe, Midtown Churches Community Association; and Miss Mary Frances Garland, South Baltimore Community Association.

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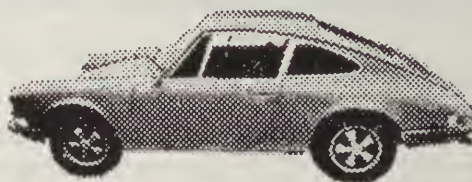
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Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced

ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.

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*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. 13. Beeson, P. B. and McDermott, W. eds. Philadelphia, W. B. Saunders Co., 1971, p. 1816.

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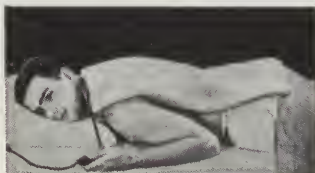
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executive director's newsletter

November 1973

MORE
ON
PRICE
CONTROLS

In the Oct 9, 1973 issue of the American Medical News, it was reported that, to all intents and purposes, the Price Control Commission intends to keep the lid on increased medical care costs. The 2.5% price increase imposed on physicians/dentists and other individual health care providers will be continued into the indefinite future.

While Jan 1, 1974 is the next time a review will take place, it is understood the Commission will probably recommend continuation of this freeze.

The American Medical Association has made strong pleas and recommendations that controls on physicians be removed, citing the excellent record over the past 2½ years on the part of physicians in conforming with the law. Despite this, no change is in the offing.

Physicians may only increase their fees by 2.5% per year, on the aggregate, and in totals of this amount per year, if no increases took place. In other words, physicians may increase fees 5% if they have not taken advantage of the 2.5% since price controls went into effect. No increase in net income can accrue, however.

If you need clarification of any particular issue, call the Faculty office for advice and guidance.

In the meantime, if you are concerned over this continuation of price controls on physician services, write your Congressman and your two US Senators.

DRUG
CONTROL
ACTIVITY

Since regulations went into effect regarding prescribing or dispensing of amphetamines and methamphetamines, there seems to be some confusion. Physicians may write and pharmacists must fill any prescription written by a physician or other authorized person.

The only control on the physician involves his record keeping and report (in summary form) of the reasons for his continuation of this practice. Some pharmacists have been reported as refusing to fill physicians' prescriptions. No change in the law has been made in this regard. Provided it is valid, a pharmacist has no right to refuse honoring such an Rx.

LEGISLATIVE
ACTIVITY

Look for an active 1974 General Assembly session. Information is at hand that a record number of bills will be introduced affecting physicians and their medical practice.

Items such as triplicate prescription blanks for physicians; repeal of the section of the drug substitution law dealing with notification to a physician as to the drug substituted; change in the Health Services Cost Review Commission to bring physicians under its jurisdiction (this group, effective July 1, 1974, has the right to set hospital charges and certify they bear a reasonable relationship to the cost of rendering such service), and many more are anticipated.

APPEAL RIGHTS
RIGHTS
IN
PEER
REVIEW

Physicians are reminded that an appeals mechanism exists in all cases involving peer review or other complaints adjudicated by local societies.

The appeal right is open both to the physician and the complainant or third party requesting a review. Appeals must be made in timely fashion.

RESOLUTIONS
FOR
ANNUAL
MEETING

Resolutions for the Annual Meeting must be received in the Faculty office before Friday, Feb 22, 1974 in order to be considered by that House. This in accordance with Faculty Bylaws, Article XI, Section 26.

MEDICARE
FEE
STANDARDS
DISCLOSURE

A US District Court has ruled that Social Security may not keep secret the fee screens of physicians in areas throughout the country. HEW has decided not to appeal this ruling. Blue Shield will now have to make available Medicare Part B physicians' prevailing charge standards. It will not make public individual physician charges, however.

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AND
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EXHIBITS

If you have one or more of these exhibits available for the 1974 ANNUAL MEETING, April 17, 18, 19, please fill in applications which are published elsewhere in this JOURNAL.


Executive Director

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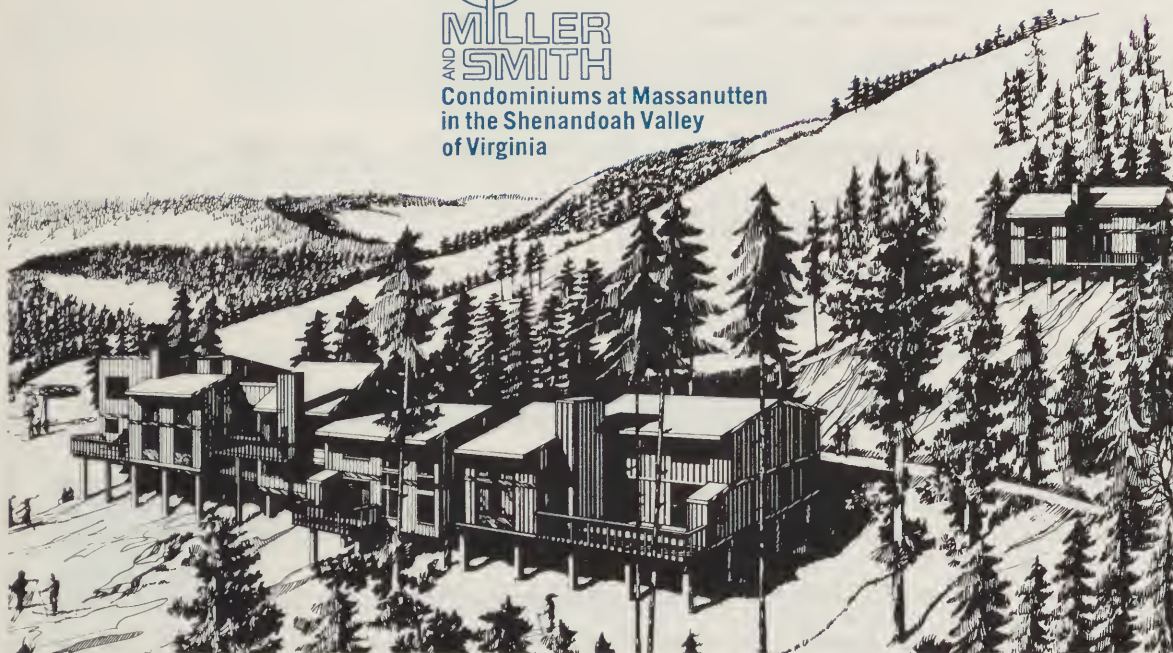
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| Nov | 27 | *Acute Respiratory Failure: Causes, Monitoring & Mgt , Holy Cross Hosp, Silver Spring, 1-4 PM. Sponsor: Med Advisory Comm of TB&RD Assoc of Frederick, Howard & Montgomery counties. Contact: Mrs Margaret Besman, 170 Rollins Ave, Rockville Md 20852, (301) 881-6852, 3 hrs cr |
| Dec | 1 | *Bicentennial Geriatrics Symposium , Baltimore City Hospitals, 9 AM-4 PM. Contact: Dr E G Beacham, Baltimore City Hospitals, 4940 Eastern Ave, Baltimore Md 21224, (301) 342-5400 ext 647, 6 hrs cr |
| Jan | 18 | Cancer Interdisciplinary Symposium , Washington. Contact: Lombardi Cancer Symposium, Rm 1301, Georgetown Univ Sch of Med, 3800 Reservoir Rd NW, Washington DC 20007 |
| Jan | | Family & Systems Theory & Family Psychotherapy , postgrad crs for nonpsychiatrist physicians, Washington. Meets quarterly in 3-day sessions. Contact: Dr Murray Bowen, Dept of Psychiatry, Georgetown Univ Med Cen, Washington DC 20007 |

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|-----------|--------|---------|--|
| Mar | 7-Apr | 11 | Selected Topics in Gen & Family Practice, Pt II , 5:00-7:30 PM, 6 Thursdays, \$50, Prog Chmn: EJ Kowalewski MD |
| Feb | 6-June | 12 | Internal Medicine in Review , 5:30-7:30 PM, 19 Wednesdays, \$50, Prog Chmn: DT Lewers MD |
| Nov | | 15 | Psychiatric Problems in Med Practice, Pt I , \$35, Prog Chmn: VaHuffer MD |
| Dec | | 6 | VD in Adolescents , \$35, Prog Chmn: FP Heald MD |
| Dec | | 13 | New Developments in Auscultation of the Heart , \$50, Prog Chmn: L Scherlis MD |
| Jan & Feb | | 31
1 | Problem-Oriented Record, Medical Audit & Utilization Review , \$100, Prog Chmn: Drs Kushner, Rapoport & Wentz |
| Feb | | 14 | Psychiatric Problems in Med Practice, Pt II , \$35, Prog Chmn: VaHuffer MD |
| Feb | | 28 | Recent Advances in Obstetrics , \$35 Prog Chmn: EB Middleton MD |
| Mar | | 7 | Dermatology Day , \$35, Prog Chmn: HM Robinson MD |
| Mar | | 13-15 | Problems & Process in Internal Medicine, Advances in Internal Medicine Considered in Problem-Oriented Manner , \$150 (Residents \$90), Prog Chmn: Drs Staniford, Rapoport & Kushner |
| Mar | | 24-26 | Advances in Practical Neurology , \$125, Prog Chmn: Drs Nelson & Price |
| Mar | | 28 | Psychological Management of Handicapped Child , \$35, Prog Chmn: Drs Cornblath & Seabold |
| Apr | | 11 | Emergency Medicine—Role of Shock Trauma Unit , \$35, Prog Chmn: Wm Gill MB |
| May | | 16-17 | Clinical Review of Transfusion Therapy & Blood Clotting Disorders , \$100 (Residents \$75), Prog Chmn: RB Dawson MD |
| Jun | | 6 | Symposium on Pediatric Neoplasia , \$50, Prog Chmn: MJ Wizenberg MD |

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(For info on these postgrad crs, contact ACP, 4200 Pine St, Philadelphia Pa 19104.)

- Dec 5-7 **Current Concepts of Clinical Infectious Diseases**, Univ of Virginia Sch of Med, Charlottesville
- Jan 7-11 **Workshops in Physiology, Diagnosis & Treatment of Electrolyte & Acid Base Disorders**, Univ of Penna Sch of Med, Philadelphia
- Jan 9-12 **Chemotherapy of Infectious Diseases: New Developments**, Univ of California, San Diego

MISCELLANEOUS MEETINGS

- Nov 29-Dec 1 **Recent Advances in Ob-Gyn**, New York City. Contact: Ob-Gyn Society of New York Med Col, 1249 Fifth Ave, New York NY 10029
- Nov 23-24 **Radiology in Otolaryngology & Ophthalmology**, conf, Chicago. Contact: Prof Valvassori, Radiology Dept, Abraham Lincoln Sch of Med, PO Box 6998, Chicago Ill 60680
- Nov 29-Dec 1 **Virology & Immunology in Human Cancer**, natl conf, Waldorf-Astoria Hotel, New York City. Contact: Dr S L Arje, Natl Conf on Virology & Immunology in Human Cancer, American Cancer Society, 219 E 42nd St, New York NY 10017
- Nov 29-Dec 2 **Amer Assoc for Clinical Immunology & Allergy**, anl mtg, Hilton Palacio Del Rio, San Antonio. Contact: Dr R J Brennan, Amer Assoc for Clinical Immunology & Allergy, 3471 N Federal Hwy, Ft Lauderdale Fla 33306
- Dec 6-7 **Emergency Dept Legal Institute**, Fairmont Roosevelt Hotel, New Orleans. Sponsors: Health Law Center of Aspen Systems & ACEP. Contact: R T Johnson, Amer Col of Emer Physicians, 241 E Saginaw St, East Lansing Mich 48823
- Dec 6-7 **Endoscopy in Gynecology & Infertility**, New York City. Contact: Dean, French & Polyclinic Med Sch & Hlth Cen, 481 8th Ave, New York NY 10001
- Dec 6-7 **Gynecologic Endoscopy**, postgrad crs, Livingston NJ. Contact: Dr J L Breen, Dept of Ob-Gyn, St Barnabas Med Cen, Old Short Hills Rd, Livingston NJ 07039
- Dec 7-8 **Perinatology Symposium**, Miami. Contact: Div of Cont Med Educ, Univ of Miami Sch of Med, PO Box 875, Biscayne Annex, Miami Fla 33152
- Dec 10-14 **Diagnostic Ultrasound Physicians Trng Crs**, Philadelphia. (also March 25-29 & May 20-24) Fee \$200. Basic indoctrination for physicians interested in establishing active program of diagnostic ultrasound in own hospitals. Contact: Dr Barry Goldberg, Dept of Radiology, Episcopal Hospital, Front St & Lehigh Ave, Philadelphia Pa 19125
- Jan 2-5 **Pediatric Nephrology**, seminar, current concepts in diagnosis & mgt, Miami Beach. Contact: Div of Cont Med Educ, Univ of Miami Sch of Med, PO Box 875, Biscayne Annex, Miami Fla 33152
- Jan 3-6 **Anesthesiology: Cardiovascular System**, 11th anl postgrad seminar, Playboy Plaza Hotel, Miami Beach. (For contact, see Jan 2-5)
- Jan 6-10 **Neuro-Ophthalmology**, seminar, Sonesta Beach Hotel, Key Biscayne Fla (For contact, see Jan 2-5)
- Jan 7-9 **Surgery of Nose & Paranasal Sinuses**, Rosenstiel Med Sciences Bldg, Miami (For contact, see Jan 2-5)

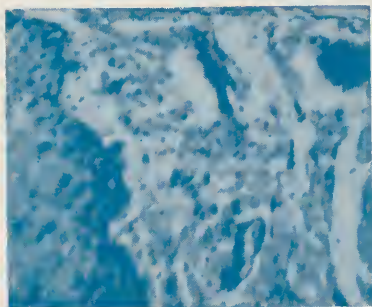


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EDWARD L. SHERRER JR. MD
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pathology

Part 1

The Clinician and Microbiology

VICTOR FAZEKAS MD

Dr Fazekas is Associate Pathologist, Mercy Hospital, Baltimore.

In spite of significant advances that have been achieved in the past 25 years in the treatment of infectious diseases and in epidemiology, infections per se still continue to be one of the major causes for hospitalization or complications in the hospitalized patient. It is estimated that approximately 20% of all clinical laboratory examinations are handled by the microbiologist. In the past, his role was to isolate and identify infecting organisms. Today, his role has undergone considerable expansion. He is now an important partner in the search for appropriate antibiotics and he can be helpful in the evaluation of the adequacy of therapy. He can measure the serum concentration of some of the more toxic antibiotics in the patient with compromised renal function. He plays a vital role in surveillance and in the epidemiologic studies of nosocomial (hospital acquired) infections. In all these functions, he needs the cooperation of the clinician, house staff, and all who are concerned with patient care.

In an effort to promote this goal, I shall deal briefly with some aspects of microbiology, such as specimen collection and handling, transportation, interpretation of the report, and antibiotic sensitivity. A few specific comments concerning blood, spinal fluid, throat sputum, stool, urine, and wound cultures, with a brief comment concerning anaerobic cultures will also be included.

The old axiom that a laboratory test is no better than the sample it is performed on is particularly true in microbiology. A fresh, properly collected sample is an absolute must for reliable bacteriological work. The time of collection, source of material, and test requested should be clearly noted on the requisition. Upon arrival at the laboratory, the carrier should

time stamp it in. Except anaerobic cultures, most of the routine material will not need special handling or transport media in the usual hospital setup. The specimens collected with swabs should be protected from drying out. To minimize drying out nonabsorbent cotton, or preferably dacron swabs, should be used. Ideally, two swabs are preferred to insure adequate material for gram stain and planting on various culture media. If delay is unavoidable, the specimen should be placed into a transport medium. This medium contains no nutrient and has a low redox potential to suppress oxidative changes. For beta hemolytic streptococci, the Todd Hewitt broth; and for *Salmonella* or *Shigella*, Selenite or GN broth are satisfactory. Transgrow medium proved to be very satisfactory for the collection, transport and culture of *Neisseria gonorrhoeae*. The bottle should be kept in an upright position to minimize the loss of CO₂. This system can be stored in refrigerator in a clinic and even in a private office. Once inoculated it will keep the organism viable from 48 to 72 hours.

It has become increasingly clear in recent years that anaerobic bacteria are important causes of many different types of infections in man. The elaborate and somewhat cumbersome system originally designed for growth and isolation of these organisms discouraged the pathologist and microbiologist from using them routinely in the clinical laboratory. Several recent large-scale, double-blind studies (mostly unpublished yet) have confirmed that the conventional Gas Pak (product of BBL) system is satisfactory for establishing and maintaining anaerobic conditions in the equipment used in the clinical laboratory. The only significant difference found in these studies was the importance of collecting the specimen in the absence of oxygen. Some of the more fastidious anaerobes are rapidly killed by oxygen. The specimens must be promptly delivered to the laboratory for immediate culturing. Specimens may be transported in commercially available anaerobic tubes or bottles having been flushed with oxygen-free

CO₂ gas before sterilization. There are also double-tube anaerobic systems for swabs which have a small amount of liquid at the bottom (anaerobic indicator included).

It is important that material is collected deep from the center of the wound rather than from the edges. Perhaps the most ideal and least expensive collection and transportation device for liquid specimen is a disposable plastic syringe. After the specimen is collected, all air bubbles should be expelled from the syringe and needle. The needle tip should be inserted into a sterile rubber stopper or a sterile cap applied to the syringe and delivered at once to the laboratory.

The obvious question which one must consider is what specimens to culture anaerobically. It is probably desirable to culture all wounds anaerobically. In the broad sense, wounds will include abscesses, traumatic and postoperative wound infections, and exudate from any serous cavity. Sputum, female genital tract, and intestines are not routinely cultured since these sites are quite rich in anaerobic flora. Most anaerobic organisms are slow growers and usually should be left in the Brewer jar for 48 hours before examination. While final identification may require considerable amounts of additional work, including gas chromatography,

a gram stain should be of considerable help in grouping the isolates into genera. Most anaerobic gram negative rods will belong to *Bacteroides* species. Anaerobic gram negative cocci can be reported as *Veillonella* species and anaerobic gram positive cocci are reported as such. Most gram positive bacilli with characteristic morphology will be *Clostridia*. The Kirby-Bauer antibiotic sensitivity method has not yet been found completely satisfactory for the anaerobes. While the disc diffusion method is probably used by most laboratories, the clinician should understand the limitation of it; we routinely make a note on the report of the fact that the in vitro result may not correlate with the in vivo response.

One of the most simple and useful procedures in microbiology is the gram stain. It gives an idea of the predominant organism, if any, and this may guide the therapeutic approach. It also will help the technologist to plan intelligently and select the most appropriate culture media, and may give a clue in special instances (sputum) to the adequacy of the specimen. The clinician should be encouraged to look at these preparations.

The next part of this article will cover the clinical importance of various cultures.

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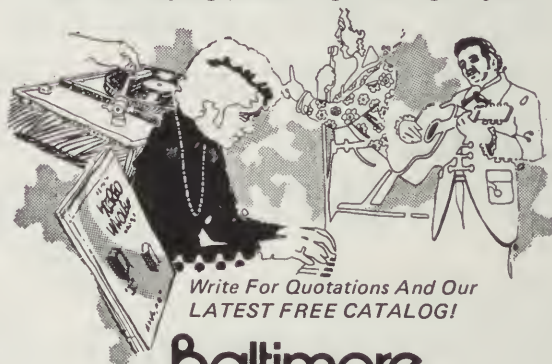
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"A niche of usefulness and self-respect exists for every man, however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave 'he cathedral without spire. To restore him, and with him the future of our countries, that is the sacred work."

John Galsworthy

FREDERICK J BALSAM MD
Editor

rehabilitation medicine

THE ROLE OF SPORTS IN REHABILITATION OF THE HANDICAPPED.

Part 3: The Wheelchair Games

NORMAN B ROSEN MD

Dr Rosen is Assistant Physician-in-Chief and Director of Rehabilitation Therapies for the Maryland Rehabilitation Center, 2301 Argonne Dr, Baltimore Md 21218; Consultant in Rehabilitation Medicine to North Charles General Hospital and Kernan's Hospital for Crippled Children; and Instructor in Rehabilitation Medicine at the University of Maryland School of Medicine.

Previous sections of this paper have focused upon the role of physical exercise as an aid in more rapidly rehabilitating the disabled person. In particular, the importance of sports and competitive athletic activity to achieve this more rapid reconditioning has been stressed.

Thus, what originally began as local attempts in several countries to publicize the skills of the wheelchair-bound by focusing on their ability to participate in "normal" athletic activities ultimately grew to international proportions. In the 1950s, the efforts of several countries to formally organize on an international level culminated in the establishment of the Paralympics. These games, known also as the International Stoke Mandeville Games, the Paraplegic Olympics, and the World Games for the Handicapped, have been held every four years, usually in the country which has hosted the International Olympics.

In addition, the Stoke Mandeville Games are also held on a smaller scale annually on the playing fields of the Stoke Mandeville Spinal Injuries Center just north of London. Furthermore, in the Americas, biennial international competitions are held. These are known as the Pan-American Wheelchair Games. In the United States, yearly regional events culminate in the United States National Wheelchair Games.

As interest in the various games has grown, so have the numbers of competitors, competitive events, and spectators. In 1972, the medieval town of Heidelberg, in the heart of the Neckar valley, welcomed more than 1,000 participants from 43 nations in the largest wheelchair athletic competition ever held (see photo pages). These

games, as did the 20 Stoke Mandeville Games that preceded them, stood as a memorial to the determination, dedication, and perseverance of those who competed, and as evidence to the able-bodied world that these participants, and many other disabled people like them, could perform well in activities that previously had been considered to be beyond their skills and capabilities. Indeed, this was one of the founding concepts behind the Games—that emphasis be placed on ability rather than disability.

It is the purpose of this section to discuss the specific events in which the wheelchair bound athlete can compete. The need to establish classification systems based on the nature and severity of disability and the classification systems used to fairly group competitors with widely divergent degrees of disability was discussed in Part 2 of this paper and will not be reviewed here. However, the reader should keep in mind that there are two major classification systems. It is the International Classification System that determines eligibility for the International Wheelchair Games and the yearly Stoke Mandeville Games. The United States Classification System governs the United States National Wheelchair Games and the Pan-American Games.

The International Games and the Stoke Mandeville Games are strictly for the spinal-cord diseased or injured and thus exclude other wheelchair-bound athletes, including congenital and acquired amputees, and other orthopedic and neurologically impaired. Patients with these latter disabilities, however, are eligible to compete in the United States National Wheelchair Games and the Pan-American Wheelchair Games.

Competition

As the spectator watches the wheelchair athlete in competition, he immediately becomes aware that the demands made on the wheelchair-bound competitor are just as strenuous, and require just as much skill and determination, as those

required of the able-bodied athlete. Indeed, the wheelchair athlete does compete in the same types of events as does his able-bodied colleague—track and field events, fencing, archery, weightlifting, swimming, basketball, table tennis, bowling, and snooker—with only a few minor modifications needed to accommodate the wheelchair. In addition to wheelchair basketball, other team sports for the wheelchair athlete including softball, football and water polo have also been initiated in the United States and abroad.

Rules Modifications

In most of the aforementioned events, the modifications of the rules governing competition are really quite minor—aside from the obvious requirement that the wheelchair participant must compete from a wheelchair, that he must not in any way be tied down to the chair, and that the wheelchair must conform to certain minimum and maximum height standards. Only in wheelchair basketball do the rules significantly differ. Thus, in other events, such as the various field events (discus, shotput, javelin) the rules are modified by specifying that the chair must be secured within the confines of the throwing circle and that no part of the chair or competitor may cross this line; in swimming, all starts begin in the water; in weightlifting, all lifts are of the bench-press type; in table tennis, touching the table is allowed if the participant has a high level lesion and therefore precarious trunk balance; and in fencing, the positions of the opposing wheelchairs are fixed within a fencing frame.

Track and Field

The competitive events themselves provide a great deal of variety and appeal—a tribute both to the imagination of the organizers and to the determination and flexibility of the competitors. This is best seen in the track and field competitions, where the largest number of individual events occurs.

Wheelchair track competition features dashes of 40, 60, and 100 yards, and distance runs of 220, 440, and 880 yards, and a mile. Teams compete in the 240 and 400 yard shuttle relays and the 880 yard and mile distance relays. However, by far, the most demanding of the track events is the wheelchair slalom.

The wheelchair slalom combines total wheelchair control and maneuverability with speed, endurance, flexibility, and frank wheelchair gymnastics. The competitor in this event must negotiate an obstacle course of 60 to 80 yards, including jumping his chair on and off two platforms, one measuring about four inches in height, and the other four to six inches. He

must wheel his chair up and then down a ramp leading to a three-foot platform, and then must traverse a slalom course through eight gates, perform a variety of reverse turns and movements, and finally complete a 15-yard straight-away dash to the final gate.

The major field events in which the wheelchair athlete can participate include the discus, shotput, javelin, and precision javelin. This latter event requires precision in hitting a target 33 feet away (23 feet for women).

While the field events themselves do not essentially differ from those in which the able-bodied participate, the drama of these events is accentuated when one realizes the limited muscular resources available to the wheelchair participant.

Archery

Wheelchair archery was one of the first sports available to the wheelchair athlete. This event was introduced by Sir Ludwig Guttmann in England as he attempted to devise a variety of activities in which the handicapped could participate. Indeed, the very first Stoke Mandeville Games in 1948 consisted only of archery competition.

Archery is a sport in which the wheelchair-bound can compete on a par with the able-bodied archer. Indeed, wheelchair archery is conducted in accordance with International (FITA) rules. Unlike other wheelchair events, however, there are no separate classifications based on the degree of disability. The only limiting requirement is that the participant must hold the grip of his bow with one hand (although a stabilizer may be used), while the *fingers* of the other hand draw, hold, and then release the string. (Obviously, the more severely involved quadriplegic is unable to participate with success in this event).

Pentathlon

The significant role of archery in the history of wheelchair sports is further reinforced by its inclusion as one of the five events of the Pentathlon. The participants in this latter event must also compete in swimming, the javelin throw, the shotput, and the wheelchair dash.

Swimming

In swimming competition, all starts begin in the water (obviously dives are not practical). The more severely involved classes compete in 25-yard front free style, back stroke, and the breast stroke events whereas the less severely involved classes participate in events of longer distance and in various medleys. One must keep in mind while witnessing these events that para-

lyzed areas of the body can cause considerable drag and that any motion in the water, particularly on the part of the quadriplegic participant, is accomplished at the expense of a markedly diminished vital capacity and also possibly impaired upper extremity function.

Fencing

Wheelchair fencing was recently added to the list of international competitive events. Competition occurs in three events: foil, sabre, and epee. In order to do this, it was necessary to make several modifications to the existing international rules of the Federation Internationale D'Escrime.

The wheelchair is secured within a fencing frame so that the chairs are parallel to each other and at a specified angle (15° to 20°) to the median line. Maximum height standards for the wheelchair seat and armrests have been established. Neither fencer is allowed to rise from the seat of the chair during the course of the competition. In the foil and sabre events, the fencer has the option of removing the armrests of his chair to allow him greater flexibility of motion—and, parenthetically, increased vulnerability to his opponent's weapon; in epee competition, however, he does not have this option and the armrest must be removed, thus increasing his vulnerability as well as his mobility and, consequently, his overall swordsmanship.

It is obvious that only the lower disability classes are capable of competing in these events since the higher lesions not only lack the necessary body balance but also the necessary wrist and hand function to securely grasp the weapon and the necessary triceps function required to actively extend the elbow for the thrust. Successful competition, in addition, obviously depends on well coordinated upper extremity function. It is this coordination and agility that determines the overall caliber of swordsmanship which is the essence of both able-bodied and wheelchair fencing.

Basketball

It is wheelchair basketball, however, that has become one of the most popular wheelchair sports for both competitor and spectator. The ability to maneuver a wheelchair rapidly and to propel the chair while dribbling the ball add additional appeal to the more traditional aspects of an already appealing sport. Thus, the elements of teamwork, shooting precision, ball handling, and sheer endurance remain integral parts of the game.

Basketball has been modified for the paraplegic more than any other wheelchair sport. The modifications to the standard basketball

rules involve the center jump and the dribble and establish regulations forbidding the wheelchair player from raising himself from his seat at any time, thus giving him an unfair advantage. The center jump modification also forbids the player from lifting himself from the seat of his wheelchair for the same reason. Violation of this rule constitutes a "physical advantage foul" and is treated as any other foul. However, three of these violations by any player will result in his being disqualified from the game.

The rules concerning the dribble are interesting in that, in order to perform this activity, the player may either wheel his chair while bouncing the ball, as is done in regular basketball, or he may first wheel his chair by applying no more than two pushes to the wheels. He must then bounce the ball before shooting or passing it or before he pushes his chair again. (International rules require that he dribble the ball prior to initially wheeling the chair.)

Other regulations specify that play stops when a player falls out of his chair (however, only if he falls in the direct line of play) and that the three-second zone under the offensive basket be increased to six seconds.

Probably the main innovation to wheelchair basketball was the assignment of point values to each player, based on his disability classification. Thus, a Class I (United States Classification) athlete would be assigned one point, a Class II, two points, and a Class III, three points. At no time can the total number of points among the five players on the court amount to more than 13 points (according to the National Wheelchair Basketball rules) or 11 points (according to the International Wheelchair Basketball rules).

Thus, in contrast to the United States rules where a team may be composed of three Class III athletes and two Class II players, according to the International rules, a Class I participant must be on the court at all times. It is readily apparent that this modification, and particularly the International approach, was designed to allow and encourage the more severely disabled individual to participate in wheelchair basketball.

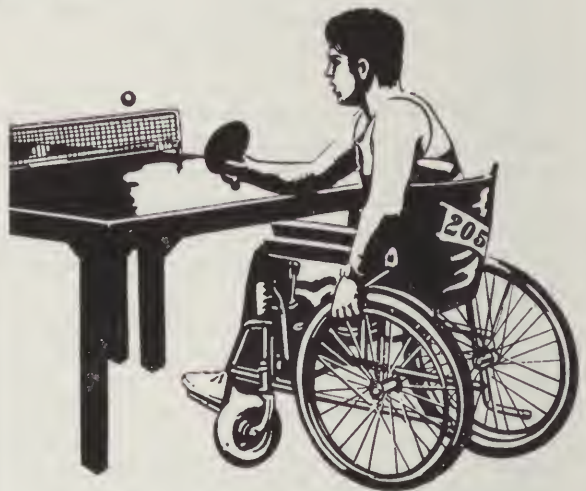
Sports' Role

And, indeed, is this not the message of the entire wheelchair sporting program? That in order to create a desire and need on the part of the handicapped person to perform, and achieve, in any activity, all that is necessary is the making of minor modifications to the established "rules," so that the disabled can also participate with enthusiasm, with dignity, and with self-respect.

International Stoke Mandeville Games

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The paraplegic athlete, symbol of the 21st International Stoke Mandeville Games in Heidelberg, Germany.

SHOTPUT—The wheelchair is fixed within the throwing circle.

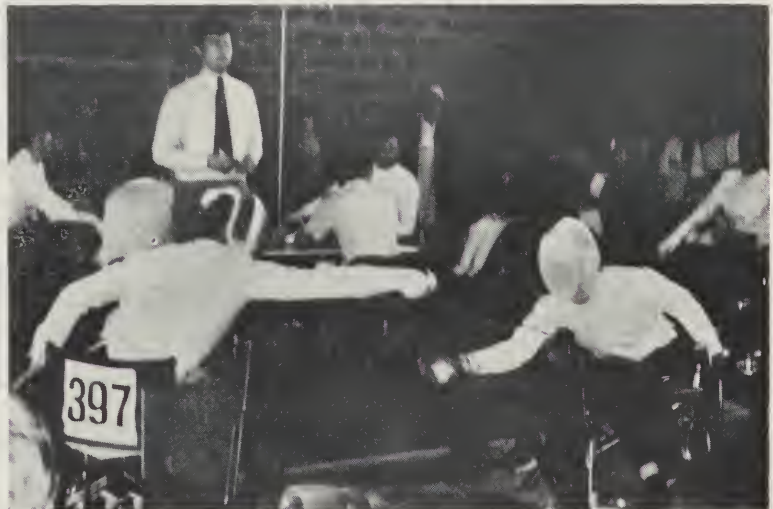
JAVELIN THROW—Distance and precision predominate in the javelin throw.





BASKETBALL—Although wheel-chair basketball is the best known of the team sports and the only one played in the International Games, participation in wheel-chair football and softball has also been introduced.

FENCING—The competitors' wheelchairs are prepositioned and fixed on opposite sides of the central line, emphasizing swordsmanship rather than footwork.



ARCHERY—One of the earliest competitive events introduced for the wheelchair-bound was wheel-chair archery.





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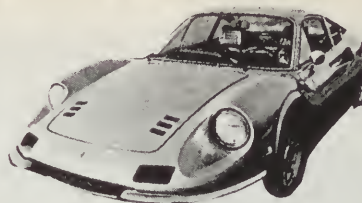
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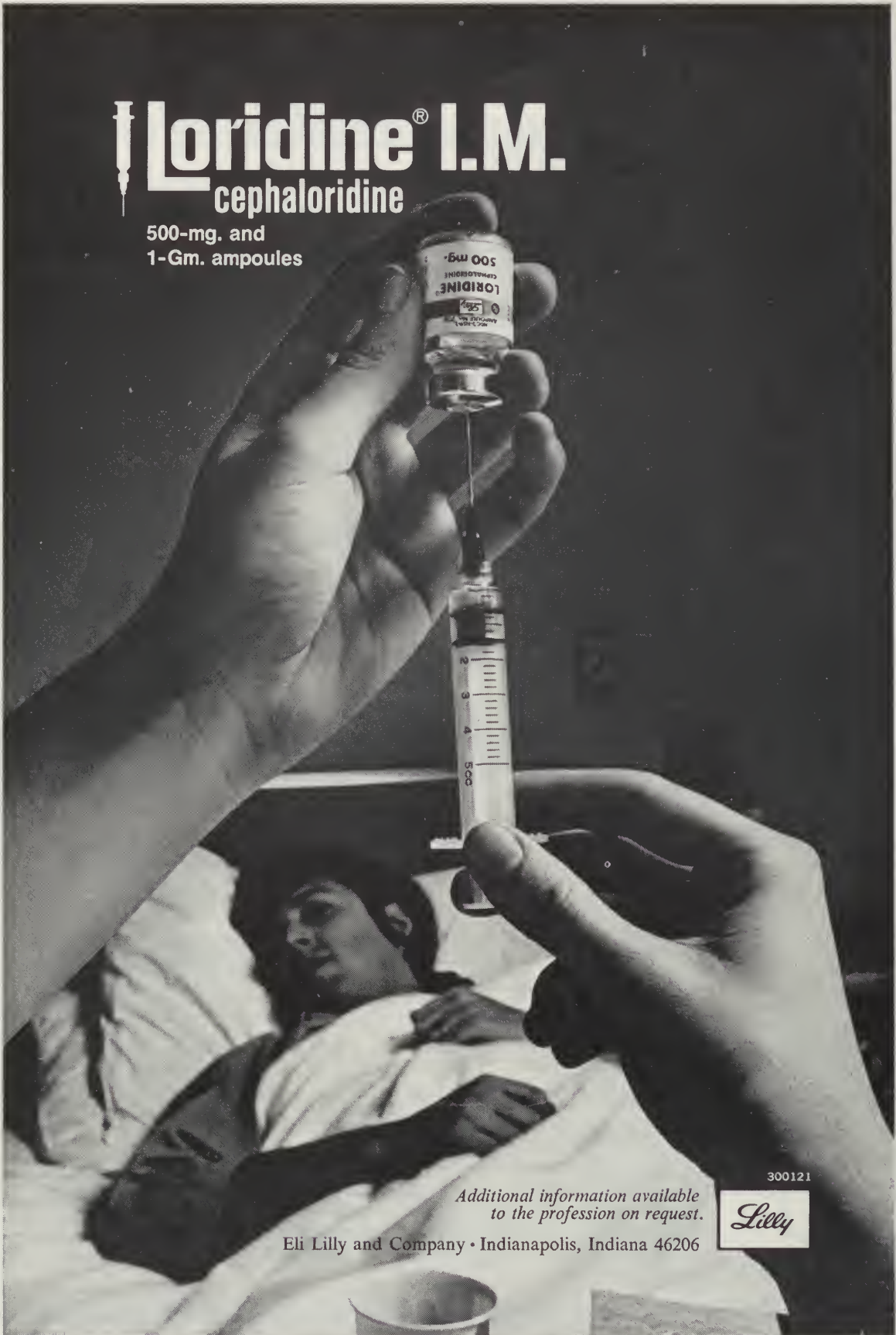


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TOWARD A THIRD CENTURY OF PROGRESS

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Dr Beacham is Chief, Chronic Medical Care; Dr Carroll, Chief, Rehabilitation Medicine; and Mr Hubbard, Executive Director, Baltimore City Hospitals.

Acknowledgment is made to the Chiefs of Departments and Divisions of the Medical Staff of Baltimore City Hospitals for their cooperation in putting together the material for this comprehensive article.

Information and reprint requests to Dr Beacham at Baltimore City Hospitals, 4940 Eastern Ave, Baltimore Md 21224.

Abstract

The Baltimore City Hospitals completes its second century of service in November 1973. Two hundred years have seen its evolution from an Almshouse created by the Maryland State Legislature in 1773 to a respected municipal teaching hospital.

There have been major changes in social, financial, and medical practice in the last decade calling for radical changes in diagnostic methods, treatment, methods of rendering health care, meeting social problems, and financing medical practice.

The purpose of the Baltimore City Hospitals for the next 100 years is to bring to our patients and community the very best medical care using every innovative financial resource available to assure the lowest cost to the taxpayers of the City of Baltimore. An integral part of this purpose requires the training of physicians and allied health personnel.

These needed changes promise to be more far reaching than in any other period in the life of the Baltimore City Hospitals.

This article will present medical and administrative policy changes in response to challenges of the past decade.

Recent Improvements

Baltimore City Hospitals became separated from the Department of Public Welfare in 1965. At that time, a separate policy making board (known as the Hospital Commission) was set up for the Hospital. This seven-member group is appointed by the Mayor and confirmed by City Council. Its role is to serve in essentially the same capacity as boards of trustees of other hos-

pitals. Thus, it plays an important role in policy formation, planning, capital funding and other major changes to be made within Baltimore City Hospitals. Additionally, it represents the Hospital to the City government. (Board of Estimates and City Council) as well as to other outside organizations.

City Hospitals has been very fortunate in the high calibre of people who have been appointed to the Hospital Commission since its inception. The current Commission is chaired by Mr Leroy Hoffberger. This group meets at least monthly on regular Hospital matters as well as three regularly scheduled meetings per year with all physician Chiefs of the Departments and Divisions of this Hospital, at which time medical policies and other medical matters are discussed. All appointments to the Medical Staff are made by the Hospital Commission.

Twelve years ago, Baltimore City Hospitals consisted essentially of large open wards. These wards were inadequate in a great many ways, including the lack of privacy, lack of plumbing facilities, lack of air conditioning, lack of call systems, and a great many other deficiencies. Since that time, a large modernization program has taken place which is now nearing completion (see Table 1). The end result is that we now have patient accommodations in semi-private and private rooms with no large wards remaining. Patient areas are air conditioned and have all of the facilities, furniture, and equipment one would expect to find in a modern, up-to-date institution. We have also constructed new areas for our Clinical Laboratories, Operating Rooms, Delivery Rooms, Pharmacy, and Nurseries. An entirely new Emergency Department has been added which easily accommodates the present load of approximately 75,000 emergency visits per year. The Emergency Department contains its own X-ray and laboratory services for immediate diagnostic determinations. It is staffed around the clock with house staff in each of the major clinical services with a back-up of the full-time staff.

These modernization projects have resulted in a modern hospital bearing little resemblance either in physical facilities or in staffing to the picture of Baltimore City Hospitals of 12 years ago. Additionally, we have improved the pa-

Table 1: Building Program Baltimore City Hospitals (1947-1973)

1947	Outpatient Department with House Staff Quarters
1954	Tuberculosis Hospital (C Building — 300 beds — Pathology)
1958	Renovation Infirmary Building (D Building — 750 beds)
1965	House Staff Garden Apartments (100 units) Addition Acute Hospital — new entrance, chapel, Medical Records, Pharmacy, Administrative unit, Emergency Room, Extension Obstetrics-Gynecology with delivery suite, Newborn Nursery — Premature unit, extension Surgical floor with Operating rooms, Offices, Intensive Care Unit
1968	Gerontology Research Center (4 stories, \$7.5 million)
1968-70	Renovation Infirmary Building (1968-West, 1-70-East)
1969-71	Renovation Acute Hospital — Center wards 1969, East and West 1971; Clinical Auditorium, Harrison Medical Library, Kiwanis Burn Unit, Post Office, Doctors' Lounge, Hospital Board Room, X-Ray Department
1971	Coronary Care Unit
1973	Renal Dialysis — Renal Transplant Unit

tient care facilities in our Long-term Care unit (the Lord Building) and have made a drastic reduction in the average length of stay in that unit due to intensified services. The federal government has constructed on the grounds of Baltimore City Hospitals a Gerontology Research Center which is the largest research center on Aging in the world. The cross-fertilization that is obtained from these scientists meeting with the Hospital staff has been mutually beneficial.

We have also constructed 100 apartment units for Interns and Residents here on the grounds of the Hospital. These apartments are separated from the Hospital but close enough so that the house staff can easily communicate back and forth and are available for emergency needs in the Hospital all of the time. These apartments have resulted in improvement in our recruiting of house staff, attracted primarily by the excellence of teaching afforded by the full-time staff of Baltimore City Hospitals. Each of the physicians of this institution has a faculty appointment at one or both of the local medical schools. They represent a somewhat unusual combination of research and education orientation as well as a strong motivation for service to our patients.

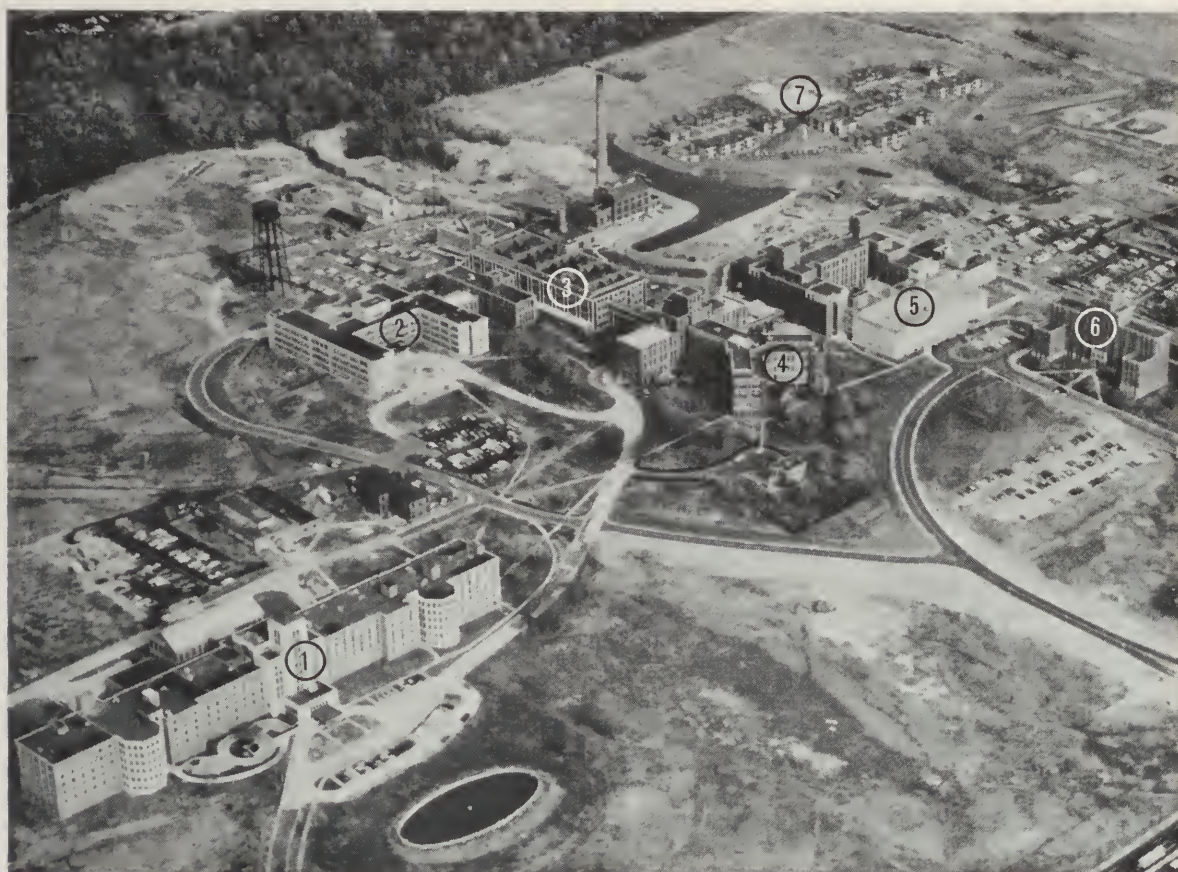
One of the major issues that has been facing the Hospital Commission and the entire Hospital is the requirement to reduce the size of the City's contribution to the operation of this institution. This has become necessary because of the financial straits of the City of Baltimore.

The City, over the period of the 200 years of existence of this institution, has been very concerned with providing a good level of health care at Baltimore City Hospitals and has done all within its power to finance these activities towards improving patient care. However, the cost of operating Baltimore City Hospitals has continued to go up each year during the last several years as have the costs in all other institutions.

The City has found this rising burden too much to bear at the same time that it is faced with other mandatory increases for other parts of the City's responsibilities. Therefore, the City has informed the Hospital that it must find ways of reducing the City's payments for its share of the operation. The Hospital is required not only to meet increasing operating costs, but also to reduce the City's share altogether. This twofold charge has been given a great deal of careful consideration by the Hospital Commission and significant steps have been taken towards this end. So far, the City's contribution has been reduced to the same dollar level that existed in 1959. Thus it can be seen that the huge impact of increased cost and the decreased value of the dollar in the interim have been covered from other sources, mainly from third-party payors. It is the objective of the Hospital and the City to reduce this figure even further.

For example, the Hospital recently began a system of itemizing billing for Ambulatory Patients which will more clearly reflect the cost of providing individual services to each individual patient. Heretofore, we were on an average-per-visit charge. It is felt that this itemized charging for Ambulatory Patients will not only be more fair to the patients, but will reflect itself in increased income to the Hospital from third-party payors such as private insurance companies, Blue Cross, and others. It is not appropriate that the taxpayers of Baltimore should pick up costs that rightly belong to these third-party payors.

The Business Services of the Hospital are being improved and modernized in order to better determine cost figures and to have available information for filing the multitude of reports required by third-party payors in order that revenue can be increased. We anticipate that there will be a steady decline in the City's contribution for running this organization over the next several years. However, with this prospect firmly before us, we still do not refuse any patient who comes here for care because of his inability to pay the bill. The tradition of this



IDENTIFICATION of the various sections of the Baltimore City Hospitals complex follows, according to the superimposed numbers:

- 1) Mason Lord Memorial Building, evolved from the 1866 Almshouse.
- 2) TB Sanatorium, built in 1953, and now in partial use.
- 3) Gerontology Research Center, built in 1968.
- 4) Original Chronic Hospital, constructed in 1911.
- 5) Old General Hospital, built about 1933, with a new addition in 1965.
- 6) Nurses Home, dates from the 1930s.
- 7) Housestaff Garden Apartments, built in 1965.

hospital, as well as others, for providing free care is difficult to change. However, the financial future of this institution depends on its recovering a much greater percent of its cost than it does at present. Ambulatory Services are one of the largest areas of loss in the Hospital and thus must be addressed in this manner. We hope to maintain at least the same number of Ambulatory Patients supported by fair and equitable charges. We plan that no one will do without necessary medical attention irrespective of ability to pay.

In addition to these steps, there has also been a significant reduction in the number of people employed by the Hospital to provide patient

care. These steps have been taken with a view towards the current census and trying to keep our operation in line with patient needs. Personnel costs represent about two thirds of the total cost of operation; therefore, that has been the area of primary attention for cost reduction. We are also looking at various ways of economizing in the area of supplies and equipment. The Hospital's operation is compared on a monthly basis with groups of similar hospitals who report to a centralized national computer set up for this specific reason. Therefore, we are able to compare ourselves monthly with hospitals in Maryland as well as with three other sample groups of similar hospitals throughout the

United States. Continuing efforts will be made in this regard in all aspects of hospital operation.

Baltimore City Hospitals was faced with a very serious dilemma of an increasing magnitude between one and two years ago. This had to do with the recruitment and retention of physicians. Prior to October 1972, all of the physicians at Baltimore City Hospitals were Civil Service employees. This meant that the jobs were classified according to Civil Service specifications which did not provide the flexibility necessary to reflect current specialization. Civil Service was cooperative and understanding but limited by City Charter requirements for uniformity. The fringe benefits that were provided to the physicians fell far below that being offered by other teaching institutions. Thus, the Hospital was at a serious disadvantage because it could not recruit individual physicians with specialized talents; it could not have enough flexibility in what they were to be paid; and it could not offer competitive fringe benefits. At the same time, the Hospital was precluded from charging usual and customary professional fees to third-party payors because the physicians were on full-time salary in a teaching institution. Other institutions that did not have full-time staff of course were charging these fees and recovering them. Therefore, the idea was born of forming a separate Corporation of the physicians at City Hospitals so that the problems of being Civil Service employees could be overcome. Fees could be charged to third-party payors to afford better fringe benefits and, hopefully, eventually better salaries, thus eliminating considerable expense to the City.

This new nonprofit organization, known as Chesapeake Physicians Professional Association was created effective in October 1972. All of the physicians of Baltimore City Hospitals belong to this organization. The Hospital pays CPPA for the services of the physicians that have to do with administration, teaching, and supervision. The Corporation, in turn, charges third-party payors for professional fees and, with these two sources of income, pays the salaries and fringe benefits for all of the physicians. There have been many problems concerned with the formation of this new body which is somewhat unique in the method of its operation. However, the Corporation is viable and is looking forward to a sound financial future. The goal is to provide enough financial incentive for Baltimore City Hospitals to be competitive with comparable teaching institutions. We have not attained that goal but are taking steps, with the help of CPPA, towards that end.

The community that surrounds Baltimore City Hospitals has made several requests for the Hospital to furnish services in various neighborhoods around Baltimore City Hospitals. The first occurred two years ago when a local private practicing physician left the State and his patients were without acceptable alternatives to them for care. As a result of their asking help from Baltimore City Hospitals, a small practice has been set up in the immediate neighborhood of these people with the services of a young physician we were able to recruit. The cost of operation of the practice is borne by the fees that the practice generates. It is not owned or operated by Baltimore City Hospitals, but we do furnish back-up for diagnostic services, inpatient care, etc. We also are involved with helping to recruit physician staff as well as other staff needed to operate the practice. The second such group was started one year ago in O'Donnell Heights, a neighborhood quite different in that it includes only those residents of a public housing project. Again, Baltimore City Hospitals has provided back-up services for this practice but does not own nor operate it. A third such group has requested services and a practice will be established in that housing project in the near future.

We feel that Baltimore City Hospitals needs to respond to community needs. These needs are being expressed by the community as facilities located in the various neighborhoods which are convenient and which provide quality patient care. Although we cannot provide physicians from our staff to go out and operate these units, we do feel an obligation, particularly as a City-owned institution, to give support for these activities whenever and wherever we can. We are meeting regularly with a considerable number of community organizations talking about health problems that they have and offering advice and other kinds of assistance wherever we can. The number of private physicians practicing in Southeast Baltimore appears to be diminishing; it looks as though this decrease will be even more rapid in the future. It is questionable how far this institution can go in replacing these lost services, but at least we are making an endeavor to help out wherever possible. Thus, the policy of the Hospital is changing from that of providing services only within its walls, to a policy of providing services wherever and whenever we can as fits the desires and needs of the various Southeast Baltimore communities we serve.

Medical School Relationships

Baltimore City Hospitals' close relationships with medical schools dates back to the date of

inception of the University of Maryland Medical School and Johns Hopkins University Medical School. The teaching of medical students and house staff has been incorporated into the Baltimore City Hospitals as a major function. During the existence of this hospital, there has been a change from doctors in training providing practically all patient care services with little supervision to the present day more sophisticated teaching organization at Baltimore City Hospitals. Currently, all of the services are headed by full-time physicians, all of whom hold a faculty appointment at one or both of the local medical schools. These physicians provide the teaching as well as the supervision and administration of their services. This has meant not only that the medical education provided at this institution is of a very high caliber but also that patient care directly benefits from these very well qualified physicians.

For many years now, there has been a teaching agreement between Baltimore City Hospitals and the University of Maryland Medical School and the Johns Hopkins University Medical School. This agreement provides that faculty and the facilities of Baltimore City Hospitals will be available to the medical students of both institutions. It also provides for a procedure whereby Chiefs of the various services at this institution are nominated. This Nominating Committee consists of equal representation from each of the three participating units. The vote of this Nominating Committee must be unanimous and thus we are assured of complete agreement on the nominees for these critical positions. The Chairmanship of this Committee rests with one of the two medical schools, depending upon the service involved. The operation of each of the services at Baltimore City Hospitals is under the control of the Chief of the Service. However, the medical student teaching programs are formulated and implemented with close cooperation between Chief of the Service at City Hospitals and the Chairman of the appropriate department at the medical school. Our experience has been that this type of cooperation between these three units has been of benefit to all. A significant percentage of the medical students from the local medical schools receive an important part of their clinical experience at this institution. Obviously, these educational standards have had a great deal to do with the quality of care provided to all patients at this hospital.

Therefore, over many years we have seen a continuing and meaningful involvement of the medical schools in the teaching and indirectly in the care of patients at Baltimore City Hos-

pitals. Because teaching is such an integral part of this institution, and as a matter of fact a requirement of the City Charter, we look forward to the future of continuing medical school involvement and perhaps at an even greater degree than in the past.

Social and Medical Background

Baltimore City Hospitals begins its third century of community service in November 1973. Two hundred years have seen evolution from an Almshouse, created by the Maryland State Legislature in 1773, to a respected municipal teaching hospital. This presentation will deal only briefly with the historical development. Challenges since 1965 have changed the Hospital to its present posture and sensitized it to its potential future role in the medical care delivery system of the community.

An Almshouse, situated outside Baltimore City, was opened in 1774 to care for the infirm, the orphans, the sick, the insane, the psychopaths, and the juvenile delinquents of Baltimore. In 1822, as its first site was engulfed by the growing city, the Almshouse was moved farther out. Once more, in 1866, the institution then called Bay View Asylum was moved to its present site in the eastern end of Baltimore.

The medical community was interested from its inception. First the University of Maryland Medical School and then Johns Hopkins University School of Medicine used patients for study as well as furnished medical care. A closer relationship occurred in 1910. At that time, Dr Arthur M Shipley, of University of Maryland, was appointed Surgeon-in-Chief, and Dr Thomas Boggs of the Hopkins was appointed Physician-in-Chief.

Other appointments were, from Hopkins, Dr Milton Winternitz as Pathologist, and Dr Esther L Richards as Psychiatrist-in-Chief; and, from Maryland, Dr Gordon Wilson as Chief of the Tuberculosis Sanatorium. From that time, students from both medical schools had part of their training at City Hospitals and the resident postgraduate program gradually developed. As part of the enlarged medical program, a Nursing School opened in 1911.

The impulse for continued quality medical care for indigent patients continued. In 1925 the name was changed to Baltimore City Hospitals and in 1935 it was incorporated into the Department of Public Welfare. In this same year, a new Acute Hospital was opened, followed rapidly by a Tuberculosis Hospital, and a new Nurses' residence. Since then there has been a continual building program at the Hospital and with it a continual increase and broadening of medical services.

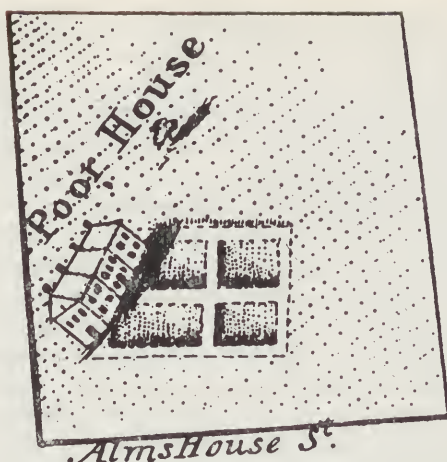


Fig 1: The first Almshouse (1774-1822), located at Biddle and Eutaw streets. From the Warner and Hanna 1801 Map of Baltimore.



Fig 2: The second Almshouse (1823-1865), located at Franklin and Presstman streets in West Baltimore. From JHB Latrobe's *Picture of Baltimore*, 1832.



Fig 3: The third Almshouse (1866-). This building has since been renovated and is now the Mason Lord Memorial Building on the grounds of the Baltimore City Hospitals.

The importance of full-time physicians for stability of the Hospital, for teaching and research function, was recognized early. In 1937, Dr Frank Kendell became full-time Pathologist. In 1942, Dr Howard K Rathbun finished his residency in Medicine and started full-time work. Dr Harold Harrison came in 1945 to reorganize the Department of Pediatrics and Dr

Table 2: Full-time Chiefs of Service, Baltimore City Hospitals

Pathology	
1937	Dr Frank B Kendell
1945	Dr Gardner Warner
1952	Dr H W Keschner
1953	Dr Abou Pollack
1972	Dr Rafael Garcia-Bunuel
Pediatrics	
1945	Dr Harold Harrison
Radiology	
1945	Dr Frederick Mandeville
1946	Dr Stanley Macht
1949	Dr John De Carlo Jr
1965	Dr Gaylord Knox
Medicine	
1952	Dr George S Mirick
1962	Dr Francis Chinard
1963	Dr Julius Krevans
1970	Dr Charles Carpenter
1973	Dr Philip Zieve
Dentistry	
1954	Dr Glenn Waring
1968	Dr Alex Drabkowski
Obstetrics-Gynecology	
1955	Dr Paul Molumphy
1962	Dr Frank Kaltreider
Anesthesia	
1955	Dr Peter Safar
1961	Dr Thomas DeKornfeld
1963	Dr Joseph Redding
1970	Dr Peter Chodoff
Surgery	
1956	Dr Mark Ravitch
1966	Dr Richard Steenburg
1970	Dr Gardner Smith
Tuberculosis	
1956	Dr Edmund G Beacham
Physical Medicine & Rehabilitation	
1956	Dr Douglas Carroll
Psychiatry	
1961	Dr John O Neustadt
1965	Dr Robert Ward (acting)
1966	Dr Louis A Faillace
1972	Dr Chester Schmidt
Gerontological Research Unit	
1940	Dr Edward J Stieglitz
1941	Dr Nathan Shock
Chronic & Community Medicine	
1963	Dr Mason F Lord
1965-66	Dr Edyth Schoenrich (acting)
1966	Dr Lawrence E Shulman
1970	Dr Edmund G Beacham
Clinical Laboratories	
1964	Dr Howard Rathbun
Neurology	
1973	Dr Oscar Marin

Frederick Mandeville joined the staff as Radiologist.

By 1956, all Departments had full-time Chiefs (see Table 2). Dr Harrison continued in Pediatrics and was joined by Dr George S Mirick as Chief Physician in 1952. Dr Abou Pollack became Chief of Pathology in 1953. Dr Glenn

Waring accepted the position as Chief of Dentistry in 1954. In 1955, Dr Peter Safar began to reorganize the Department of Anesthesiology and Dr Paul Molumphy reunited Obstetrics-Gynecology as its full-time Chief. In 1956, Dr Mark Ravitch became Chief Surgeon, Dr Edmund G Beacham was made Chief of the Tuberculosis Department, and Dr Douglas Carroll was made Chief of Physical Medicine and Rehabilitation.

In 1961, Psychiatry left Medicine to become a Department, and Dr John O Neustadt was appointed Chief. In 1963, Dr Mason F Lord was made Chief of the Department he developed—Chronic and Community Medicine. Dr Howard K Rathbun, long-time Director of Laboratories, became Chief of Clinical Laboratories in 1964.

With these developments, training of interns and residents became more formal. Baltimore City Hospitals had long been noted for training opportunities and patient management responsibilities for its house staff. Now, under a full-time senior staff, closer monitoring and guidance were available. The part-time, university-associated physicians have never been appropriately recognized and thanked for their years of hard, conscientious efforts on behalf of patients and resident physicians at Baltimore City Hospitals.

DEPARTMENTS

Obstetrics-Gynecology

The changes that have taken place in the Department of Obstetrics-Gynecology reflect the community forces and medical progress of recent years. When Baltimore City Hospitals opened its new hospital in 1935, Obstetrics was incidental and Gynecology was part of Surgery. An attempt was made to divide Obstetrics under the medical school professors, Dr Nicholas J Eastman of Hopkins and Dr Louis H Douglass of Maryland, for residency coverage. This program was soon abandoned and the residency program was supervised by the University of Maryland with consultants from both medical schools.

The Gynecology service grew until 1953 when it became a separate Department under Dr Beverly C Compton; two years later when it was thought appropriate to have a full-time staff, the newly created Department was combined with Obstetrics under Dr Paul J Molumphy. By 1958, the number of deliveries reached 6,000 per year and gynecologic procedures numbered over 1,000.

Dr Irving Cushner was acting Chief for two years until Dr D Frank Kaltreider was appointed in 1962. During the last two years BCH has experienced the same healthy decline in birth rate as has Baltimore City, has maintained

an active Gynecology service, with an explosion of the Outpatient Department, and an active participation with the Division of Neonatology so that prenatal mortality rates have been reduced and a continuous residency program which has recently integrated with the program at Johns Hopkins Hospital. About one third of University of Maryland medical students receive all their Obstetrical and Gynecological experience at Baltimore City Hospitals.

Pediatrics

Dr Harold Harrison has organized the Department of Pediatrics to care for children from the neonatal period through adolescence. The Acute unit has 39 beds and averages 1,500 admissions yearly. It has special provisions for surgical cases, operates a Burn Unit with the Division of Plastic Surgery, and an Intensive Care unit for infants with low birth weight, congenital anomalies, or birth trauma.

Patients come to the special Pediatric Intensive Care Unit from all over Maryland and occasionally from nearby states. Emergency transportation is provided by helicopter service of the Maryland State Police. The Unit can care for 30 infants and admits approximately 500 per year. In addition, there is a 45-bassinette Newborn Nursery for infants without special problems. The newborn service also has a program for drug-addicted mothers and their infants which provides special care and follow-up to determine the effects of maternal addiction on the development of the infant.

The Pediatric Outpatient Service at BCH provides for emergency care, diagnostic studies, specialty pediatrics, and preventive medical care. A Child and Youth Health Center is supported by a federal grant which provides for total medical care to children living in a specific geographic area comprising the O'Donnell Heights Housing Project, and also to foster children, wards of the City of Baltimore. This program provides a model for continuity of total care, including preventive medicine, parent education, detection of functional problems of hearing, vision, speech and learning, as well as diagnosis of organic disease and treatment of acute and chronic illness. There are 35,000 patient visits per year to the various Pediatric Outpatient services.

The Department of Pediatrics has an important teaching function parallel to its role in caring for the health of children. In this teaching program, 15 interns and residents gain experience in child health services including all aspects of pediatric medicine. Medical students from both schools participate in inpatient and

outpatient programs. The Department has also contributed to the development of new knowledge in diseases of childhood—particularly in the areas of lead poisoning, problems of kidney function, calcium metabolism and disorders of the skeleton, treatment of respiratory difficulties of the prematurely born infant, treatment of leukemia, and viral infections of early infancy.

Surgery

The Department of Surgery already had an illustrious history by 1956 when Dr Mark M Ravitch was appointed as its first full-time Chief. Under Dr Ravitch's astute guidance, the Department further evolved as a clinical teaching service for students from both the University of Maryland and the Johns Hopkins University. An excellent postgraduate teaching program continued and expanded in General Surgery, and the Surgical Specialties continued to provide training for residents from affiliated services, primarily from the Johns Hopkins Hospital.

Dr Ravitch was followed in 1966 by Dr Richard W Steenburg, who maintained the full-time tradition and an excellent teaching program. Dr Gardner Smith, when he became Surgeon-in-Chief in 1970, completed integration of the general surgical program so that the entire Surgical Department was affiliated with the Johns Hopkins Hospital program.

In 1956, Dr J Donald McQueen assumed direction of the Neurosurgery Service and has continued to provide leadership in teaching, training, and research. In 1959, the Orthopedic Service came under the leadership of Dr Gerhard Schmeisser, and it continues to provide exceptional teaching and training opportunities under his guidance. Each of the specialties has full-time direction today. The men who head these services, each dedicated to patient care in an academic environment, include Dr Dennis Gleicher in Ophthalmology, Dr Edward Cohn in Otolaryngology, Dr C T Su in Plastic Surgery, and Dr Alesandro Basso in Urology.

Under the direction of Dr Thomas J Krizek, the Kiwanis Burn Center was developed with the joint efforts of the Kiwanis Club of Highlandtown, the Baltimore City Fire Department, and the Mayor and City Council of Baltimore. The Center has remained under direction of the Division of Plastic Surgery as the only such facility in the State of Maryland; it has flourished under the guidance of its present director, Dr C T Su.

A strong effort has been maintained in the Surgical Research Laboratories during the past 16 years. Opportunities for training and for re-

search have been provided for many groups and the following endeavors should be emphasized: stapling techniques in general surgery, burn studies in plastic surgery, in vitro activity of lysosomal enzymes, classification of intracranial hypertension, and allied studies in experimental subarachnoid hemorrhage and head injury in Neurosurgery. Scanning techniques in nuclear medicine were initiated at BCH in the clinical Neurosurgical Laboratory. Brain scanning began in 1957 and for many years all scans were carried out there. Cisternal scanning in Baltimore was first carried out in this same laboratory.

Another significant contribution has been in the field of transplantation. The importance of this field was first recognized and fostered by Dr Richard Steenburg, who organized a dialysis service in the Department of Surgery and initiated a renal transplant program. More recently, the Dialysis Program has been directed and expanded under the auspices of Dr Jimmy Zachary in the Department of Medicine, while the Transplantation Program, operated as a closely cooperative venture, has been under the direction of Dr Sylvester Sterioff. Just this year (1973), this joint venture has moved into a newly built and highly modern Transplantation and Dialysis Center.

Department of Anesthesia

In 1955, the Anesthesia Department was made an independent Department. In its 18-year history, it has had three distinguished anesthesiologists as full-time Chief. All of these men have gone on to make unique and important contributions to their specialty. The first director was Dr Peter Safar, now Professor and Chairman of the Department of Anesthesiology at University of Pittsburgh School of Medicine. While at BCH, Dr Safar developed an approved residency program, medical student training program, and began his pioneering work in emergency artificial respiration. In 1958, he started the first Medical-Surgical Multidisciplinary Intensive Care Unit in the United States with 24-hour coverage by anesthesiologists. He also upgraded the Baltimore Ambulance Service from a primarily transportation capability to the capability of lifesaving and life-support measures. There was also at that time an active animal research program and a clinical pharmacology program which evaluated numerous new drugs.

Dr Thomas De Kornfeld was Chief of Anesthesia at Baltimore City Hospitals 1961-1963. Since leaving Baltimore, he has had various positions at the University of Michigan where he is now a full professor in the Department of

Anesthesiology. While here, he developed the Department of Inhalation Therapy and established the School of Inhalation Therapy. In addition, Dr De Kornfeld was author of numerous, widely used text books for the training of inhalation therapists.

Dr Joseph S Redding became the next Director of the Department of Anesthesia at BCH in 1963, a position he held until 1970 when he left to assume his present position, Professor of Anesthesiology at the University of Nebraska College of Medicine. Dr Redding was deeply involved here in life-support systems, pathophysiology of various types of sudden death, and principles of critical care medicine. The present Department, under Dr Peter Chodoff, consists of five staff anesthesiologists, seven staff nurse anesthetists, four student nurse anesthetists, and four residents in Anesthesiology. In addition, there are 12 Respiratory Therapists in the Division of Respiratory Therapy. The Department is active in training both residents and nurses in the application of respiratory care to medical and surgical patients throughout the entire hospital population. There is also a separate Respiratory Care Unit in which patients requiring artificial ventilation are placed. Allied health training programs utilizing computer techniques have been part of the department's activities. All these programs are part of a plan to continue and expand the broad concept of Anesthesiology as envisioned by its distinguished former chiefs.

Radiology

The first X-ray equipment at BCH was obtained in 1919 while Roentgenology was a subdivision of the Department of Medicine. In 1935, an autonomous Department of Roentgenology was established. In 1942, Dr Arthur B King was the first to demonstrate the basilar artery in a human, using cerebral angiography.

The first full-time Chief of Service was appointed in 1945 and a Residency Training Program and School of Radiologic Technology started in 1946. In 1965, decision was made to build a new facility. Dr Gaylord Knox became Chief and planning began in earnest for the new plant which opened in 1969. The present facility occupies about 20,000 sq ft of space and offers a complete range of diagnostic radiographic facilities; it is staffed by some 70 employees.

Since 1965, a number of innovative techniques have been developed. The Department was the first in Baltimore to use terminal digit and color coding in 1965, after changing to hospital numbers for film identification in 1962. It was the first in Baltimore to use small automatic proc-

essors hospital-wide, and also the first to have a specially designed "VIP" room where these studies could fully utilize the equipment.

There are now eight full-time American Board-Certified Radiologists who give round-the clock service to the 72,000 patients who come to the Department each year. They also conduct daily conference sessions with medical and surgical staff, and participate in the many teaching sessions held throughout the Hospital.

The Division of Nuclear Medicine was created in 1969 and moved into an area of 4,000 sq ft in 1973. Ultrasound thermography and other 20th century diagnostic imaging techniques are on the horizon. The Department of Radiology intends to enter the third century of BCH history in the forefront of medical progress, striving for innovative ways of providing diagnostic information with less radiation, for few dollars, and with less discomfort and inconvenience for all.

Pathology

The names of many of the physicians who figured in the development of the Pathology Laboratory at BCH are now bywords in American Pathology. Dr W T Councilman, the first US pathologist to confirm Laveran's discovery of the malarial parasite, worked at Bay View Asylum during early days of Johns Hopkins Hospital. His name is permanently associated with peculiar bodies found in the liver of patients dying of yellow fever. Much of this work was conducted at the then Bay View Asylum. The Laboratory was subsequently directed (1888-1893) by Dr E Opie, then later by Dr George H Whipple and Milton C Winternitz. Dr Whipple went on to become a Nobel Prize winner for his work on the etiology and therapy of pernicious anemia.

In 1953, Dr Abou D Pollack became full-time Chief, renewed close ties with the Hopkins, and continued to lead the Department until his untimely death in 1971. Dr Pollack's name is associated in the annals of pathology with those of Klemperer and Baehr as the first to define conceptually the "collagen" diseases. His tenure led to one of the more fruitful periods in the department of the Laboratory. Diagnostic, teaching, and research capabilities were enormously expanded and strengthened under his guidance. Among the developments were outstanding photography laboratory, an expanding diagnostic cytopathology service, and a research laboratory which now includes two electron microscopes and facilities for investigation in tissue culture, histochemistry, radiochemistry, fluo-

rescent microscopy, and experimental radiation pathology.

Dr Pollack developed a residency program which now trains 11 young physicians each year in anatomic and clinical pathology. He improved integration with the Department of Pathology at Johns Hopkins and was named a Professor. His effectiveness as a teacher is reflected in the fact that at the time of his death all full-time members of the Department had received all or part of their training under him at BCH. The present Chief, Dr Rafael Garcia-Bunuel, is a member of that heritage, and is carrying on in the tradition of his illustrious teacher and predecessor.

Psychiatry

From its very beginnings as an Almshouse, Baltimore City Hospitals has cared for mentally ill patients. During its first century of existence, when there were few services available for the mentally ill in Maryland, the Bay View Asylum took a major responsibility for the care of mental patients from Baltimore City. During the 1880s and 1890s patients at Bay View were used for teaching of Psychiatry to the students of the new Johns Hopkins School of Medicine. Over the next 25 years, as resources were developed elsewhere, the number of insane admissions decreased. Finally in 1943, all psychiatric admissions were discontinued at BCH and mental patients were offered services by the State of Maryland Psychiatric System.

Psychiatry returned to BCH in the late 1950s and early 1960s under the direction of Dr John O Neustadt, who was appointed full-time Chief of Service in 1961, in collaboration with two part-time psychiatrists, Dr Theodore Feldberg and Dr Lex Smith. The interest and dedication of these three men resulted in renewed interest. Following Dr Neustadt's death in 1964, Dr Robert Ward became Acting Chief in 1965; in 1966, Dr Louis Faillace was appointed full-time Chief.

Under Drs Ward and Faillace, the Department developed and grew. Medical students from Johns Hopkins were assigned for clerkships. A first-year resident position was created. An Inpatient Unit and related After Care program was begun by Dr Ward. Dr Faillace brought several Alcoholism Research programs here as well as grants from the State supporting a Crisis Intervention Clinic and an Alcoholism Liaison Service. Just prior to his leaving in 1971, Dr Faillace was successful in bringing a large federal grant for a Drug Abuse Program to the Hospital.

Under the direction of Dr Richard Allen,

Psychological Services expanded their service areas of psychological testing and behavior therapies. A Behavior Clinic provides treatment for adolescent and family problems, sleep disorders, and persistent headaches. In addition, the Psychological Services invested heavily in a variety of research programs, including important work in the study of alcoholism.

Presently, the Department of Psychiatry offers its patients a full range of services. The Acute Psychiatric Unit is a 14-bed Inpatient Service, providing care to voluntarily admitted patients, and having about 30-day average length of stay. Posthospital care includes vocational rehabilitation, an after-care clinic for supportive psychotherapy and management of medications, and social work services.

The Crisis Clinic is the major outreach service, operates a walk-in Clinic five days a week, and provides support for Emergency Psychiatric Services available, day and night through the year. A recent development has been the practice of assigning personnel to community based primary care facilities, such as Highlandtown Medical Offices.

The Alcoholism Liaison Service, located principally in the Emergency Room, provides consultation and service to alcoholics entering through the Emergency Room, as well as to those admitted to other major services.

The Drug Abuse Program, now in operation for two years, has reached full enrollment of 200 addicts. Under the direction of Dr Burton C D'Lugoff and his Associate, Dr James Hawthorne, the program has had considerable success in assisting addicts maintain themselves in the community in schools, in jobs, and in their families. Child Services have been provided by Dr Myron Hafetz and several part-time psychiatrists. Dr Laurice McAfee was appointed to the full-time staff July 1, 1973 when a Division of Child Psychiatry opened under her direction.

Future developments include construction of a 20-25 bed ward for the Acute Psychiatric Unit. Research in Alcoholism and Drug Abuse continues, as well as new research interest in the use of bio-feedback mechanisms for the treatment of obesity and headaches. Dr Chester Schmidt was appointed full-time Chief of Psychiatry in 1972 to help develop balanced programs of service, research, and training.

As the State of Maryland reduces the size of its mental hospitals and attempts to shift the responsibility of care for the mentally ill to local communities, Baltimore City Hospitals will attempt to keep pace with the development of

comprehensive psychiatric and mental health programs to meet the needs of the people who rely on BCH for their health care.

Dental Service

In the *Maryland State Medical Journal* (BCH Issue, Dec 1955), Dr Glenn Waring stated: "Plans must be made to expand and widen our perspective, if dentistry is to meet the increasing needs for patients of the hospital." This statement rather appropriately serves as a preamble to recent dental program developments.

Dr Alex J Drabkowski was appointed Chief of Dental Services in June 1968 to develop an inpatient and outpatient program, postdoctoral teaching program, and an affiliation with the Dental School of the University of Maryland. At this time, all these goals have been accomplished.

The Dental Service is approved by the American Dental Association Council on Hospital Dental Service and the Council on Dental Education. Candidates from Dental Schools of Medical College of Virginia and University of Minnesota are presently serving as dental house officers, having been selected from 80 applicants.

A full range of services is available on in- and outpatient basis with a specialty back-up service for the Hospital's 606 Children's Program. Comprehensive dental care is available for the foster children of Baltimore. A Dental Clinic is conducted for the long-term care division, services are provided for handicapped and special patients, and a 24-hour emergency service is available to the community.

Cooperative arrangements have been made for students of Baltimore Community College and Bryman Medix School to come to BCH for clinical training. Summer student research programs in community dental problems are conducted in cooperation with the Department of Health and Mental Hygiene, Department of Health, State of Maryland.

Gerontology Research Center

One of the unique resources of BCH is the Gerontology Research Center devoted to study of all aspects of aging. From a modest beginning in 1940 with one research worker and one technician assigned by the National Institutes of Health, the program has gradually expanded over the years under the leadership of Dr Nathan Shock to become the locus of the intramural research program on aging conducted by the National Institute of Child Health and Human Development.

A four-story, \$7.5-million building was for-

mally opened in June 1968; this Center has a staff of 130 investigators and supporting personnel. The GRC conducts research into a wide variety of physiological, biological, medical, and psychological aspects of aging in humans as well as in other animal species.

In addition to its own research programs the GRC sponsors a Guest Scientist Program to encourage and promote research in aging. Under this program, laboratory space and resources of the Center are made available to scientists and physicians from BCH and other medical schools and universities for studies on aging. During 1972, 12 collaborative research projects operated in the Center.

The goal of the research program of the Center is to improve the quality of life in later years by reducing the incidence of disabilities and impairments which now afflict many elderly people. The program follows pathways of general description of quantitative changes in aging and of understanding basic mechanisms of aging. Four branches are involved in these studies.

The Clinical Physiology Branch, under direction of Dr Reuben Andres, places special emphasis on age changes in humans. A major activity of this branch is the operation of the Baltimore Longitudinal Study. Some 650 community-residing men, 20 to 96 years in age, have volunteered to spend 2½ days at BCH every 18 months. Since 1958, 400 subjects have been tested with a battery of clinical, biochemical, physiological, and psychological tests.

The Laboratory of Behavioral Sciences, under the direction of Dr Bernard T Engel, conducts investigation between behavioral and psychological characteristics and indices of physiological aging, especially human learning and memory.

The Laboratory of Molecular Aging, directed by Dr Bertram Sacktor, conducts investigations at the molecular, enzymatic, and intracellular levels on the causes of changes in structure and function which occur with aging.

Recent advances in scientific knowledge and technology now make it possible to devise experiments which will provide answers to many of the key questions about aging. Scientists at the Gerontology Research Center, with the continued cooperation and support of their BCH colleagues, have the skill and resources to actively pursue answers to these questions.

Emergence of Special Medical Units

Along with the general renovation of all hospital buildings and facilities, a new trend was

notable. New knowledge, the result of the scientific explosion following World War II, was available for application to patients. Small units for patients with special diseases were proliferating at a remarkable rate. Specialists were added to the staff to run them.

The Almshouse had been founded in 1773 as a solution to the multiple social problems of the time. Over the years, various functions were taken over by different private charities and state institutions. As the larger social functions were removed, new medical specialties emerged within the more clearly defined medical field. In 1890, a separate ward had been established within the Infirmary Building for tuberculosis patients. This was the first special tuberculosis ward in a general hospital in the US.

In 1935, patients in the General Hospital were divided by floor into specialties of Surgery, Pediatrics, Medicine, Obstetrics, and Gynecology. There was a special section for infectious diseases on the Medical floor, but special beds for special diseases became prevalent only in the 1950s. Then came premature infant nurseries, postoperative recovery rooms, respiratory units during the poliomyelitis epidemics, and eventually, under Dr Safar, an Intensive Care Unit.

During the 1960s, a special children's ward was opened in the Tuberculosis Hospital. With renovation of wards in the Acute Hospital, a new Burn Unit was developed by Dr Thomas Krizek, and a Pediatric Intensive Care Unit by Dr Herman Risemberg. A small Coronary Care Unit, started in one of the Medical wards, gradually developed in the 25-bed Coronary Care Unit opened in 1971 under direction of Dr Gustav Voigt, Chief of the Division of Cardiology.

A Cancer Chemotherapy Unit, starting with a few beds in the Tuberculosis Hospital, was moved to the B Building in 1962 with full staff and laboratory equipment. This unit will phase into a Cancer Center at Johns Hopkins Hospital, still under Dr Albert Owens who started the original program.

Alcoholism Research Units for Behavioral Studies and for Metabolic Studies were opened under the Department of Psychiatry. In 1968, Dr Jimmy Zachary formally opened a Renal Dialysis Unit; soon after this, Dr Marvin Schuster was made Chief of the Gastroenterology Division in the Department of Medicine.

The Medical Department had several other significant changes. Dr Julius Krevans left for California as Dean of University of California School of Medicine in 1970, and Dr Charles Carpenter replaced him. In 1973, Dr Carpenter accepted a position as Chairman of the Depart-

ment of Medicine at Case Western Reserve University in Cleveland; in July 1973, Dr Philip Zieve became Chief of the Medical Department.

In 1966, a Medical Staff reorganization attempted to bring BCH staff in alignment with Hopkins and Maryland. Since there were no Departments of Physical Medicine, Tuberculosis, Laboratories, or Chronic and Community Medicine at the Johns Hopkins Medical School, each of these Departments was downgraded to a Division. At the same time, Surgery added formal Divisions of Neurosurgery and Orthopedics. Although Anesthesia was not a separate Department at Hopkins, it was at Maryland, so it remained a Department at BCH.

Closure of the Tuberculosis and Chronic Hospitals

For years, it had been apparent that Baltimore, as well as other large cities, was having great difficulty financing necessary city services. The cause of these difficulties were many: inflation, increasing unemployment, removal of the middle class to the suburbs with an increase in percentage of inner city residents needing services. The tax rate continued to rise. State and federal financial involvement gradually increased in amount. Hospital services were gradually broken down, itemized, costs assigned, and methods worked out to collect, record, and render bills. Patients were divided into categories defined by their need for a physician, medicine, nursing, housekeeping, and domiciliary care. A bulging bureaucracy and serried ranks of computers replaced the rather informal older method of taking all costs and dividing them by the number of patient days.

Development of drugs effective in treatment of tuberculosis opened a new era in the control of this serious killer. Tuberculosis has probably caused more deaths than any other single disease in Baltimore over the last 250 years. In the late 1940s, plans were made for new Tuberculosis Hospitals to replace old ones and to try to eliminate the months'-long waiting list for beds. In 1954, 900 new beds were opened in Maryland: 300 at Loch Raven VA Hospital, 300 at Mt Wilson Hospital, and 300 at Baltimore City Hospitals.

When Isoniazide became available in 1951, and particularly when this drug was used in combination with other drugs, it became increasingly obvious that patients became noninfectious fairly rapidly, and that prolonged bed rest was seldom necessary. Certain patients with advanced disease, deteriorated alcoholics, homeless persons, and others who could not be relied on

to take medicine regularly stayed in hospitals longer than the usual patient. Many patients were treated at home; most had shorter and shorter hospital stays; so that, with less patients coming in and more rapid turnover, hospital waiting lists vanished and beds were closed.

Soon, there were only two major Tuberculosis Hospitals in Maryland: Mt Wilson in Baltimore County, and Baltimore City Hospitals Tuberculosis Division. Patients at BCH were generally sicker with more complications, selected somewhat by the availability of total general hospital facilities for laboratories, rehabilitation, and specialty consultative facilities. The State had to make a decision, and in 1969, after a year of debate, decided to close the Tuberculosis Division at BCH.

After July 1, 1969, tuberculosis patients at BCH were sent to Mt Wilson Hospital. Attempts were made to manage tuberculosis patients in General Hospitals, but through 1973 third-party funding has not been available to make this a reality. The BCH Tuberculosis Hospital remains vacant while plans are being discussed for an appropriate use.

During the late 1960s, the Infirmary (D Building) had been completely renovated. Planning as far back as 1965, under Dr Lawrence Shulman, had envisioned it as a Chronic Disease Hospital with units for special diseases—Arthritis, Stroke, Neurology, Orthopedics, Rehabilitation, and Nutrition. During 1968-1969, it became apparent that funding was becoming increasingly difficult and nurses could not be obtained to staff the new wards.

Dr Edmund Beacham became full-time Chief of the Division of Chronic and Community Medicine in June 1970 and attempted to revitalize the service under the new name of Division of Chronic Medical Care. He developed positions for three Assistant Chiefs (full-time) and four Fellows in Chronic Medical Care under the Department of Medicine at BCH and Johns Hopkins.

There were 381 patients in the D Building July 1, 1970 when Medicare regulations forced reclassification of patients and patient areas with many patients being found to be ineligible for federal coverage. State Medicaid payments were well below patient care costs, so the Chronic Care deficit borne by the City became a staggering \$2.5 million projected for the 1971-72 period.

On July 1, 1971, a temporary decision caused removal of Chronic Division physician salaries after July 1, 1972, so at that point only the Chief was left. During 1971-1972, there was a drastic

cut in nursing staff, social workers, rehabilitation staff, administrative staff, and elimination of food service in the building. The State Health Department agreed to lease part of the building for 20 years and to assume the debt payments.

City Council of Baltimore City agreed to continue to operate the Division of Chronic Medical Care at a reduced patient level (200) providing it could be maintained at a deficit of \$500,000 for 1972-1973. By careful planning and separation from most BCH functions, the Division of Chronic Medical Care came close to the rigid budgetary restrictions.

This unit has taken all long-term care patients referred by the Acute Hospital since July 1, 1971. There has been no appreciable waiting list, and lengths of stay on the Medical and Surgical Services have been appreciably affected.

The immediate future seems to call for continuation of a long-term care unit at BCH with emphasis on patients requiring higher levels of care than those afforded in Community Nursing Homes.

Nursing Service

The authors thought it appropriate to end the BCH story with an expression of appreciation to our nurses who have been our inner strength and stabilizing force over the years. A small core of senior nurses has given strong support to thousands of interns and residents on all services. A School of Practical Nursing, started in 1925, has added a steady influx of new nursing staff to carry on the rich tradition of the old and manage the bulk of nursing care.

Some names will bring strong memories to BCH physicians and medical students of the past quarter century. Deep imprints were left by Mrs Elizabeth Strawn RN, Chronic Medicine, 1928-1962; Miss Myrtle Dooley RN, Chief Tuberculosis Department nurse, 1938-1964; Miss Lena Van Horn RN, Medicine, 1940-1970; Mrs Dorothy Kottcamp RN, Pediatrics, 1944-1954; Miss Emma Pike RN, here from 1938 and Director of School of Practical Nursing, 1956-1970; Mrs Josephine Van Cura RN, in our Surgical Operating suite since 1938; and Miss Jessie Abbot RN, MS, now Director of Nursing Department after a long career starting in the Tuberculosis Department in 1947.

The present trend in Nursing is towards specialization. We look forward to having an increasing percentage of registered nurses on our staff, particularly those prepared through the Associate of Arts in Nursing Programs of our local community colleges.

LESIONS OF THE SPLENIC FLEXURE OF THE COLON ASSOCIATED WITH PANCREATIC DISEASE

DONALD H HOOKER MD
GARDNER W SMITH MD

From the Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, and the Veterans Administration Hospital.

Reprint and information requests to Dr Hooker at Veterans Administration Hospital, 3900 Loch Raven Blvd, Baltimore Md 21218.

Abstract

Lesions of the splenic flexure of the colon and concurrent pancreatic disease are unusual and present diagnostic and therapeutic problems.¹ The following three cases illustrate the difficulties which result when the relationship between these two disease processes is unclear.

Case Reports

Case 1. An 81-year-old male was admitted on Feb 14, 1972 because of cramping abdominal pain of three months' duration. He passed a little bright red blood per rectum several weeks before admission and stated that he had been a heavy drinker. In 1960, he had pulmonary tuberculosis which responded to chemotherapy. In 1963, the right great toe was removed for squamous carcinoma. Physical examination revealed the patient to be a vigorous man. There was a little mild epigastric tenderness. No other abnormalities were noted.

The laboratory studies were within normal limits except for a blood amylase of 336 U (normal 160 U). Thorough radiological studies revealed only a few calcifications in the pancreas and a constricting lesion at the splenic flexure of the colon which was thought to be malignant (*Fig 1*). At laparotomy a hard mass in the splenic flexure of the colon was found adherent to all surrounding structures. The head of the pancreas was nodular.

On the assumption that the mass was malignant, the splenic flexure of the colon, the mesocolon, spleen, edge of the stomach, and distal third of the pancreas were excised en bloc. The pancreatic duct appeared normal. The pancreatic stump was closed and drained. Several days later, a pancreatic fistula appeared. The wound broke down and the patient died one month later from a myocardial infarction. Postmortem examination revealed the colonic lesion to be due to pancreatitis and a radiopaque injection

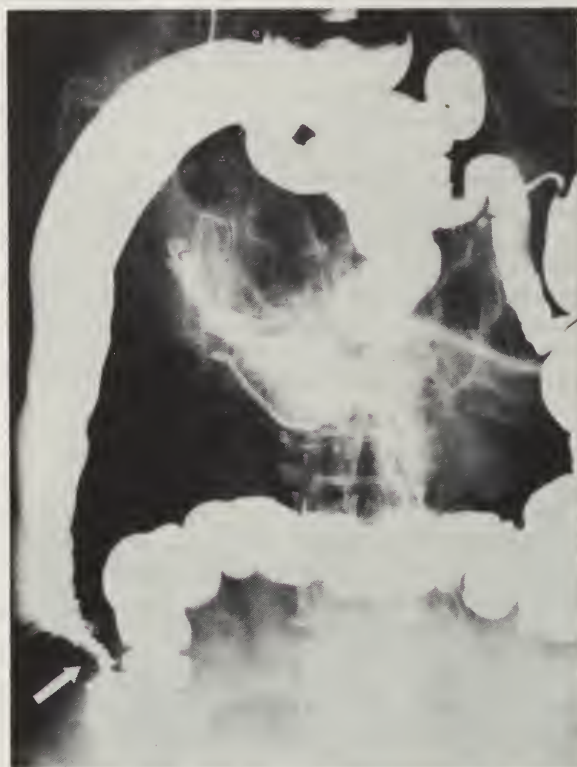


Fig 1: Arrow showing narrowed defect in splenic flexure of colon.

into the pancreatic duct (*Fig 2*) revealed an obstruction in the head of the gland.

Case 2. A 73-year-old male was admitted for herniorrhaphy in Oct 1968. For one week, he had suffered from abdominal pain and vomiting. He appeared chronically ill. Abdominal examination revealed no abnormalities except a soft left inguinal hernia. The hematocrit was 25% and BSP retention was 16%. Barium enema showed several constricting lesions near the splenic flexure of the colon. At operation, a firm mass was encountered involving the splenic flexure of the colon and adjacent structures, including the pancreas. A biopsy showed only inflammatory tissue. Since resection of the mass seemed inadvisable, a colo-colostomy was done to relieve any future obstruction. A postmortem examination two months later revealed an adenocarcinoma of the splenic flexure which had extended into the pancreas.

Case 3. A 54-year-old male was admitted in Sept 1961 complaining of abdominal pain, vomiting, and weight loss of two months' duration. The patient did not appear ill. The liver and



Fig 2: Postmortem injection of pancreas showing obstruction to passage of radiopaque material beyond head of pancreas. Arrow "A" marks orifice of pancreatic duct in duodenum. Arrow "B" marks direction of injection of radiopaque material into normal appearing duct in tail of the pancreas.

spleen were a little enlarged and the laboratory studies were within normal limits. Various X-rays revealed a persistent defect near the splenic flexure of the colon with medial displacement of the stomach and left kidney. At operation, a dense mass was encountered obliterating the lesser peritoneal sac and adherent to the adjacent structures. The pancreas was nodular. Several biopsies showed fat necrosis. No intrinsic lesion of the colon could be demonstrated. The process was assumed to be a subsiding pancreatitis and nothing further was done. His course was uneventful.

Comments

In 1927, Forlini² presented a case of stenosis of the splenic flexure due to pancreatitis. Since then, a few reports^{1,3,4} have described similar cases. Mohiuddin et al¹ reasoned that the pancreatic exudate extends within the layers of mesocolon to the splenic flexure of the colon. Cases 1 and 3 appear to fall into this category while Case 2 suggests that the mesocolon may serve as a two-way pathway since the tumor cells from the colon appeared to extend directly into the pancreas.

The crux of the therapeutic problem appears to depend on a correct diagnosis; this may be difficult to obtain. The preoperative diagnosis was erroneous in all of these presently reported cases and a correct operative assessment was made only in Case 3. Cases 1 and 2 awaited autopsy for definitive diagnosis, suggesting that an error in diagnosis may well be lethal. The pancreatic fistula which developed in Case 1 might have been prevented had an operative pancreatogram been performed.

Summary

Three patients with constricting lesions of the splenic flexure of the colon and unsuspected pancreatic disease are presented. These cases illustrate that this unusual combination of diseases presents serious problems in diagnosis and treatment. A correct evaluation is particularly important since an extensive and high risk operative procedure may be avoided.

Not: Case 1 was treated by one of the authors (DHH) at the Loch Raven VA Hospital in Baltimore. Cases 2 and 3 were treated by the other author (GWS) at the University of Virginia Hospital in Charlottesville.

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NEWER CONCEPTS IN EMERGENCY CARE OF CHILDREN WITH MAJOR INJURIES

J ALEX HALLER JR MD

Dr Haller is Robert Garrett Professor of Pediatric Surgery, and Children's Surgeon-in-Charge, Department of Surgery, Johns Hopkins Hospital, Baltimore.

This paper was read at the Pediatric Emergencies Symposium sponsored by the Medical and Chirurgical Faculty of Maryland, Prince George's General Hospital, Cheverly Md, March 29, 1973.

We hear so much about the tragic loss of children from congenital heart disease, lung abnormalities, and leukemia that we may overlook the fact that half of the children who die in the United States in 1973 will die as a result of serious injuries! Almost one half the deaths in childhood (1-15 years) in the United States are a result of accidents as compared with approximately one death in ten from injuries in the general population. A comparable situation is present in other industrialized nations. In 1964, Stolowski reported that more than one third of childhood deaths in Germany were a direct or indirect result of trauma. Major trauma is the fourth leading cause of death in the population as a whole, and the leading cause of death in children.

The death of a child is always a tragedy, but crippling injuries to a child and the resulting need for rehabilitation may have a far greater impact on society than a child's death. The expenditure of resources and personnel and the economic loss from termination of work potential when a child is seriously handicapped are relatively enormous when compared with similar losses following injuries in adults. Disability and rehabilitation create difficult adjustments for a mature, stable adult; but these adjustments, for an immature child, may be overwhelming when they are added to the natural stresses of growth and development. In 1965, more than 100,000 children were permanently crippled in the United States by accidents and another two million were temporarily incapacitated by their injuries. As the number of children increases in our country, the problems of emergency treatment and long-term rehabilitation of children with injuries must inevitably increase.

One of our responsibilities, as physicians and as parents, is to bring this problem of trauma into sharper public focus. In this way, we may enlist local and national financial support for studies of accident prevention and of the management of major injuries.

Unique Responses of Children to Major Injuries

A child may be affected quite differently than an adult by the same type of major accident. For example, the loss of a small amount of blood in a young child assumes dramatic importance when we consider his tiny blood volume. Transfusions of large quantities of refrigerated bank blood and bottled fluids may lead to a rapid loss of body heat causing dangerously low temperatures in small infants. Such heat losses are of much less consequence in adults. Congenital abnormalities, especially congenital heart defects, are more likely to be present in a child and they may complicate the treatment of his injuries.

Blunt impact accidents are responsible for the majority of serious injuries in children. They probably account for 80% to 90% of multiple injuries in this age group. In such injuries, external evidence of internal damage may be absent or misleading and result in serious delays of proper treatment. Evaluation and precise diagnosis are most difficult in children with head injuries. A child's head is injured more often than an adult's, possibly because his head is relatively larger and is also more poorly supported by his weak neck muscles. Head injuries, which are often associated with unconsciousness, greatly increase the difficulty of evaluating generalized trauma in children.

The inability of a young child to express his pain and to localize his symptoms places multiple trauma in childhood almost in the category of veterinary medicine. Because of this absence of precise communication, evaluation of an injured child demands the greatest patience and insight of the examining physician, as well as his ability to establish a meaningful relationship with a child under very unsatisfactory conditions. The physician must rely almost entirely upon objective evaluation under these circumstances.

Serious injuries in a child may have disastrous effects upon his emotional well-being at this impressionable age. The terror of separation from familiar faces is greatly magnified if a child is brought to the usual impassionate environment of a busy adult emergency room. Serious emotional after-effects are not uncommon from even minor injuries if they are treated under threaten-

ing circumstances by physicians and nurses who have no primary commitment to children as individuals. Too little attention has been given to this important aspect of emergency care. Most emergency room personnel are not fully aware of this additional emotional injury to a child, which may result from the horrible sights he may see in an adult emergency room. Anyone who has seen a child being sutured next to a bloody, swearing adult or pushed aside to transport a dying gunshot victim can imagine the memories which must follow! Unless this environment gives better care to an injured child, we believe it should be eliminated.

Finally, it has become a truism in the management of trauma that successful treatment of multiple injuries requires a trauma unit and a team approach with a single captain. The high incidence of injury to multiple organ systems and the need for command decisions which cut across specialty fields make the injured child a clear example of the need for a trauma unit. A general surgeon is best equipped by his training and experience to handle this important role. If he has additional experience in the treatment of young infants, this increases his effectiveness in the management of childhood trauma.

A Children's Regional Trauma Center

We have, therefore, embarked upon an innovative program for the delivery of emergency care to children in a new Outpatient Building at Johns Hopkins Hospital which, we hope, will become a Regional Trauma Center for Children. We are convinced that this is desirable, 1) as an area for more efficient evaluation of children with serious injuries, 2) as a center for modern resuscitation of these little patients, and 3) as an environment which is designed especially for them. Children brought into this unit will have the advantages of centralized diagnostic facilities and of specialty consultation in all surgical and pediatric disciplines.

Facilities needed for a Regional Trauma Center for Children include: 1) novel techniques for transport of injured children, both by ambulance and by helicopter with specially trained attendants; 2) a resuscitative area within the trauma unit for evaluation and lifesaving treatment of a child with multiple injuries; 3) core diagnostic facilities, including X-ray, blood, and chemistry laboratories; 4) experienced physicians and nursing staff available on a 24-hour basis within the unit and consultants in the various specialties available on immediate call; 5) adjacent intensive care areas especially designed for children and their unique problems;

and 6) available operating rooms for the surgical treatment of serious injuries which require general anesthesia.

We firmly believe that the concepts outlined here can best be translated into an operational program in a university hospital environment, with a geographically distinct Trauma Center for initial management of serious injuries and with an adjacent children's Intensive Care Unit which also provides postoperative care for children. One important concept in the management of multiple injuries in children is that routine OPD visits must be excluded from the emergency area. Orthopedic cast checks, laceration follow-ups, upper respiratory infections, and a host of other outpatient problems of semi-emergent nature must be handled in areas distinct from the trauma unit.

Many types of injuries will be managed within this first floor of the new building; for example, poisonings and caustic burns from ingestion of toxic substances; electric shock and flame burns; machine injuries such as wringer, bicycle and power mower injuries; battered children; sports injuries from competitive athletics; drownings; and injuries resulting from major automobile accidents.

In addition to highest quality evaluation and treatment of injured children, such an emergency area in the new Edwards A Park Building provides an opportunity for further learning and understanding of the management of trauma. For example, there will be opportunity to study better methods of delivering emergency care to large numbers of children. Since this unit represents the first one designed especially for children, there are opportunities for leadership and innovation in the entire field of the delivery of emergency care for both surgical and nonsurgical conditions.

We plan to utilize electronic and computerized techniques for measuring the physical impact of an injury on a child and to use these measurements in a continuous fashion to predict which children may develop further serious complications. By close monitoring of his circulation, for example, we may detect early signs of impending shock. This dynamic record of a child's response to treatment will act as a guideline for moment-to-moment management and permit rapid changes in therapy, if this is indicated, as the child recovers in our Intensive Care Unit.

Because the nature of accident evaluation and resuscitation is different from the diagnosis and treatment of illness emergencies in children. (eg, pneumonias and meningitis) different areas on

a common emergency floor are designated for these functions. To fulfill this concept, there are three distinct, but integrated, geographic units. One is for evaluation and resuscitation of major accidents and injuries which has been previously described. Another is for minor injuries, such as suturing lacerations and treating dog bites and minor abrasions. The third area is for evaluation and treatment of medical or illness emergencies. These three component units are inter-connected with diagnostic X-ray and blood laboratory facilities which are operational on a 24-hour basis. Adjacent to these units is a conference and record room for patient discussion and physician teaching so that young doctors can learn up-to-the-minute techniques in the management of serious injuries. They may take this training and experience with them to similar units as they are built in other hospitals throughout the United States.

This unit is also innovative in that it brings together, in an accident room environment, trained pediatricians and surgeons who will work as a team in the overall management of children. For example, this area may be used for the evaluation of a child with abdominal pain. After thorough examination by both pediatrician and surgeon, the child's trouble may be diagnosed as appendicitis requiring an operative form of treatment or it may be a poisoning problem which will respond to nonsurgical treatment. Within this unit, close professional interrelationship between pediatricians and surgeons constitutes a new team concept in the management of seriously ill children.

Emergency Treatment Flow Pattern

A child with multiple or major injuries will be delivered by ambulance or via helicopter to the trauma evaluation room. Because of the limited reserves of small children and the rapidity with which they may deteriorate, the technique of transportation of an injured child assumes increased importance. This requires special training of ambulance and helicopter personnel in resuscitation of infants, and simplified techniques of treatment in transit. Treatment in transit will require specially designed and equipped emergency vehicles. These should be direct radio communication with receiving hospitals to alert specialized personnel and to obtain advice in unusual situations. Communication should include determination of the appropriate medical center to which the child should be taken.

Resuscitation devices, including anesthesia machines and supportive equipment for the

heart and lungs, are immediately available in the trauma unit. Patients will be initially evaluated by either a pediatric house officer or a surgical assistant under the supervision of a staff trauma specialist. Surgical specialty consultants will be available on immediate call to examine the child here. For example, an orthopedic, or ear, nose and throat specialist would come directly to the child's bedside.

The equipment for emergency evaluation, X-ray diagnosis, and operative treatment are so designed that a patient has a minimal number of moves and the smallest possible area is covered. We have chosen an initial evaluation table which can also be used to transport a patient, and will permit X-ray and surgical management, including cardio-respiratory resuscitation, without moving a child from the initial table top. This mobile table is also appropriate for suturing minor lacerations and for postanesthetic recovery.

After resuscitation and initiation of treatment in the Trauma Center, a child may be rapidly transferred to the Intensive Care Unit in the adjacent Children's Medical and Surgical Center. When necessary, a patient may be transferred directly to the operating room for surgical management. The same doctors who are responsible for evaluation and resuscitation continue to be the primary surgical staff for the child in both the operating room and the Intensive Care Unit. This identification of responsibility assures continuity of treatment.

We believe it is unwise to provide for overnight or prolonged observation areas within a trauma unit. If prolonged observation is necessary, a child will probably receive better care as an inpatient in the intensive care unit because the demands of nursing care in a busy trauma unit preclude adequate observation and supervision of a child in such a holding area.

In summary, the emergency facilities on the first floor of the new Edwards A Park Building are operational on a 24-hour basis and include both surgical and medical components, X-ray facilities, and blood and chemistry laboratories. This unit is organized to provide primary resuscitation and initial management for extensive and multiple injuries in children. It is also staffed to provide highest quality treatment for simpler injuries and emergency illnesses in children from our geographic area, the East Baltimore community. Thus, this floor represents a complete emergency treatment center for children which is tied administratively and professionally to the ongoing Intensive Care Unit in

the Children's Medical and Surgical Center of the Johns Hopkins Hospital.

We believe this will provide highly specialized treatment for catastrophic injuries to children for the Baltimore metropolitan area in a unit which is especially planned for them. Neither the program nor the facility is designed to compete with other excellent emergency facilities in the Baltimore area which can manage routine injuries and illnesses of children. Rather, we hope that this center will be used to supplement available care in other community hospitals and thereby prevent expensive and often unreasonable duplication of highly specialized techniques for the management of major injuries in children.

If properly used, this new emergency facility in the Johns Hopkins Medical Institutions could

appropriately be called a Children's Regional Trauma Center for Baltimore and surrounding communities.

Using this type of organizational framework and a physically separate trauma unit for children, we believe improved teamwork and more efficient management of multiple injuries will result. The basic principles of rapid, careful evaluation and sequential correction of altered physiology remain the backbone of successful therapy in children. The unique metabolic demands and miniature anatomic relationships, especially of a small child, present the physician with a special challenge and a great responsibility. Rewards for the successful management of multiple trauma are high; for the younger the injured child, the greater is our total investment in his welfare and in his future.

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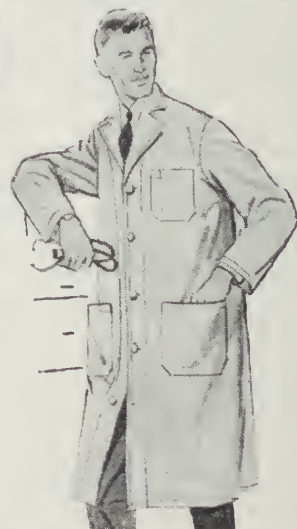
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DIABETES MELLITUS PRESENTING AS ESOPHAGEAL MONILIASIS

HOWARD P SHERR MD
ARTHUR E COCCO MD FACP

From the Department of Medicine, Division of Gastroenterology, Johns Hopkins Hospital, 601 N Broadway, Baltimore Md 21205. Supported in part by a training grant (05095) from the US Public Health Service.

Dr Sherr is a Fellow in Gastroenterology, Johns Hopkins University School of Medicine, Baltimore.

Dr Cocco is Instructor in Medicine, Johns Hopkins University School of Medicine; also Chief of Gastroenterology, St Joseph Hospital, and Church Home and Hospital, Baltimore.

Information and reprint requests to Dr Cocco.

Abstract

Candida Albicans is a ubiquitous fungus, but an uncommon and rarely primary pathogen. Such predisposing conditions as severe diabetes mellitus, debilitation, hypoparathyroidism, carcinoma, glucocorticoid use, broad spectrum antibiotics, and immunosuppressive agents, among others, have all been identified as being associated with esophageal candidiasis. Therefore, we thought it interesting when a patient presented with esophageal candidiasis as the first manifestation of chemical diabetes mellitus.

Case Report

A 58-year-old female, previously well, was referred for evaluation of dysphagia of recent duration. In the month prior to admission, the patient began having increasingly more severe burning substernal discomfort associated with eructation. Shortly thereafter, she noted that solid foods would stop in mid-chest which progressed to include liquids and was associated with an 11-lb weight loss. There was no history of polyuria, polydipsia, or polyphagia, though a sister has mature onset diabetes mellitus. Extensive questioning did not reveal any antibiotic usage, glucocorticoid ingestion, chronic illness, or immunologic deficiency.

Physical Examination

Examination revealed a thin, ill-appearing woman, looking older than her stated age. Her height was 5' 0" and weight was 99 lbs. Fundoscopic examination did not reveal diabetic retinopathy. The mucous membranes of the mouth were erythematous and white patches were evident in the oropharynx. The tongue was coated and hairy white. The breath was fetid. The remainder of the examination was noncontributory to the patient's illness.

Laboratory studies included the following: Hematocrit was 29%, WBC 9,700 with a left shift. Urinalysis was negative for sugar, protein, and casts on several occasions. Stool guaiac was

intermittently positive and serum iron was 23 mcg, while iron binding capacity was 360 mg. Gastric analysis revealed free acid. Routine fasting sugar was 75 mg, but an oral glucose tolerance test using a 100-gram dose showed the following abnormal curve: 0-75 mg, 1/2 hour, 155; one hour, 250; two hours, 264; three hours, 262; four hours, 160; five hours, 52; six hours, 67. Concomitant glycosuria was noted from one hour on. UGI series showed an abnormal esophageal motility pattern with delay of passage for the barium tablet. Esophageal motility using three perfused catheters failed to demonstrate a lower esophageal high sphincter zone or peristaltic waves. Instead, simultaneous contractions to wet and dry swallows were noted.

Esophagoscopy with the Olympus fiberoptic esophagoscope revealed a striking white patchy mucosa (Fig 1) which bled easily when brushed.

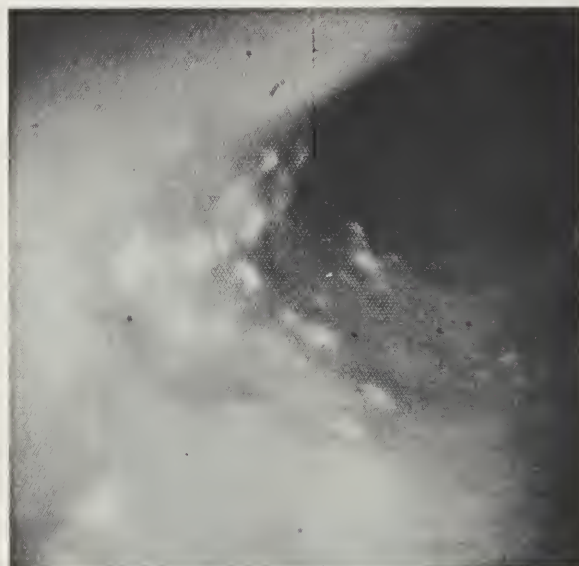


Fig 1: Endoscopic photograph of the patient's esophagus, indicating involvement with *Candida Albicans*.

The involvement was observed to include the entire esophagus but most prominently the distal esophagus and ceased abruptly at the esophago-gastric junction. No peristaltic waves were appreciated and reflux could not be demonstrated. Biopsies (Fig 2) taken at the time of endoscopy showed acute inflammation and infiltration of the mucosa by mycelia structures and budding yeasts consistent with *Candida Albicans*. Treatment was begun with oral viscous nystatin (*Mycostatin*), antacids, and oral hypoglycemic agents with a gratifying symptomatic response. The pa-

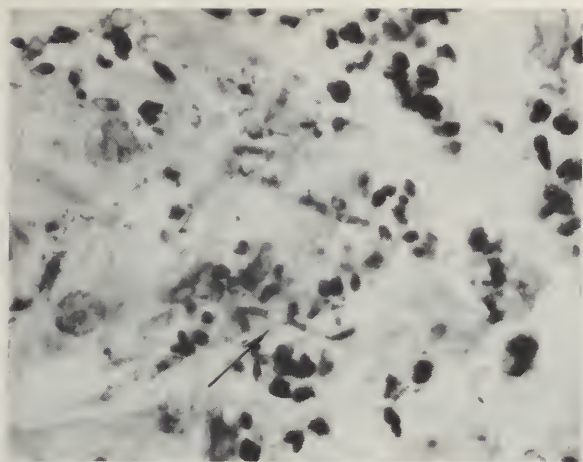


Fig 2: Biopsy specimen demonstrating budding yeast, mycelial invasion, and acute inflammation.

tient's dysphagia abated, symptoms of reflux improved, and, with improved appetite, she gained weight.

Discussion

Candida Albicans is a common fungus which can be considered as part of the normal flora of the gastrointestinal tract. In cultures of 30% of oropharynxes, 54% of jejuna, 55% of ileums, and 65% of fecal samples the organism could be isolated.⁴ Mucocutaneous and systemic involvement, though, are exceedingly rare, occurring in the setting of pre-existing disease, such as diabetes mellitus. Rarely does the patient present with a normal fasting blood sugar only to be diagnosed as diabetic in search for a predisposing condition.

Diagnosis and treatment of monilial esophagitis, once the condition is suspected, should present no problem. The setting is usually in a patient with a chronic illness as listed here, who develops dysphagia or substernal pain. The barium swallow is often quite suggestive (Fig 3)^{2,3} but it may be nonspecific as it was in this patient. Esophagoscopy with accompanying culture and biopsy is the definitive diagnostic pro-

cedure. Treatment with viscous nystatin (*Mycostatin*), 100,000 U hourly by mouth, has proven to be an effective and rapid regimen, while the more hazardous amphotericin B (*Fungizone*) should be reserved for systemic involvement.⁴

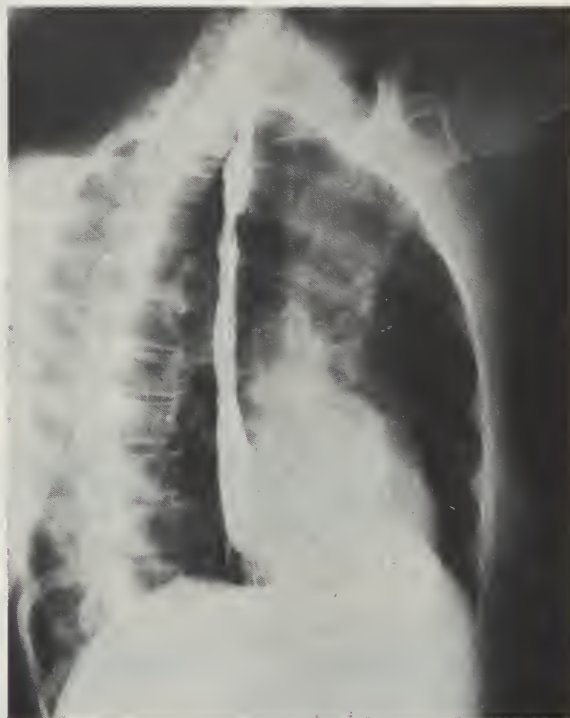


Fig 3: Barium swallow in a patient with esophageal moniliasis demonstrating typical findings.

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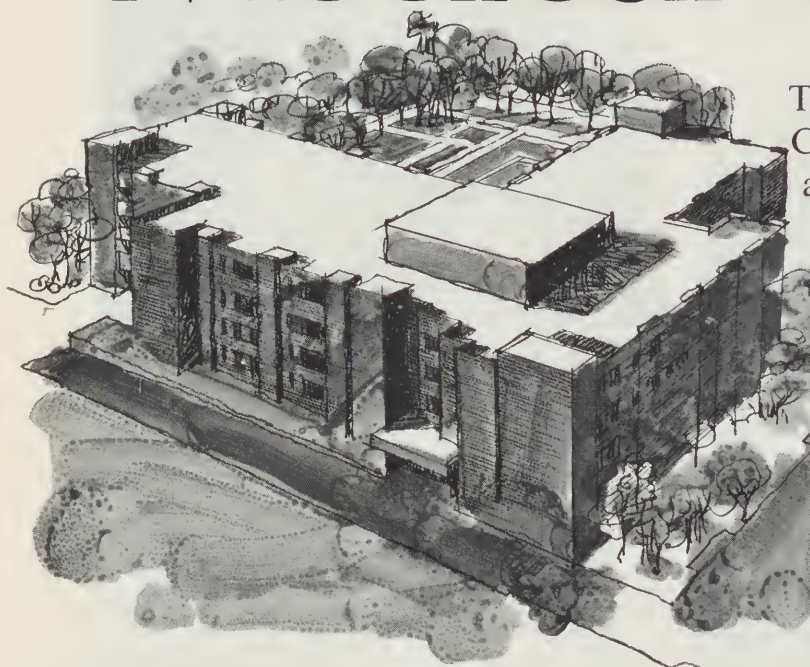
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AGING PROCESS IN SCHIZOPHRENIA

JOSEPH LERNER BS MD*

W D LERNER BS MD**

*LMAPA, Psychiatric Consultant, Arizona State Hospital, Phoenix.

**Assistant Professor, Microbiology, Medical School, University of Missouri, Columbia.

"Old soldiers never die, they just fade away." This romantic concept expressed by General Douglas MacArthur exemplifies the benevolence of some myths in our culture. It is an inescapable fact that myths are a ubiquitous and persistent element in the functional aspects of modern society. In a society where "education" has taken the place of "literacy" as a shibboleth of the "social engineers," myths continue to influence all segments of society.

Some myths tend to influence us toward false and deceptive goals which benefit neither society nor the individual. An example of a destructive and misleading myth is the widespread notion that "elegant housing" is essential to a meaningful and happy life of the elderly. This myth has distorted and confused the approach to the problems of the aging. The importance of a stable and familiar living area has not received the consideration it richly merits.

The effect of senescence in schizophrenia has been the subject of considerable interest to psychiatrists. There have been many studies concerning the terminal phases of schizophrenia in an effort to understand the total process of the disabling effects of schizophrenia. As C Muller¹ points out, attempts have been made to distinguish the different kinds of evolution of schizophrenia in the aging schizophrenic in an effort to understand the essential effects of the schizophrenic process, but most of these studies have not been of very much use in clarifying the nature of schizophrenia. Muller quotes Henri Ey to the effect that the final stages (of schizophrenia) are not the clinical expression of well-defined types of schizophrenia or real entities. Dr Ey described the aging schizophrenic as "being the organized form of the schizophrenic capacity, forms of liquidation of the bankrupt psyche which depend less on a specific process than the psychodynamic vicissitude."

The problem of the effect of the aging process on schizophrenia has assumed much greater importance in recent years because of a widespread program by state hospitals and other mental institutions to place elderly schizophrenics in nursing homes. In the past ten years or more, there has been a tremendous decrease in

the census of state hospitals throughout the country; part of the decrease in the census is related to the transfer of elderly schizophrenics to nursing homes. In view of this modern development, the problem of the aging process in schizophrenics has some very practical implications at this time. There has been some rather cogent criticism of the placement of the aging schizophrenics in nursing homes. Perhaps some of this difficulty which has caused criticism of the program of placement in nursing homes is related to inadequate screening of schizophrenics who are being considered for placement, as well as the inadequacy or inflexibility of the nursing homes to which these patients have been sent.

In the final analysis, schizophrenics who have lived to reach the senium may at times be radically different from other aged individuals who require placement in nursing homes. The basic problem in individuals who suffer from schizophrenia during the years when most individuals work for a living is the unpredictability and the ineffectiveness of schizophrenic individuals in a specific work situation. The unpredictableness and the ineffectiveness of a schizophrenic individual can be exaggerated or minimized, depending upon the specific living situation in which these individuals are placed.

When schizophrenic patients become elderly, and the process of aging has a more or less specific effect on such individuals, the basic issue is the persistence of the pattern of unpredictability and a possibility of the occurrence of inappropriate behavior patterns. When an aged individual behaves in a bizarre or even disgusting manner, the fact that he is aged is used to explain or at least to minimize the responsibility of the individual involved. When, however, schizophrenic patients are involved with this type of unacceptable behavior, it is common to find that the nursing home staff and the general public tend to criticize those professionals who have participated in the transfer of an elderly schizophrenic patient to a nursing home. The placement of the elderly schizophrenic generally requires a broader and more individual program so as to provide adequate psychotropic medication; in addition, there must be skilled nursing care and mental health clinic supervision, as well as adequate rehabilitation and occupational therapy services.²

The problems of the aging, in addition to the aging schizophrenics in our society, are neces-

sarily the focus of many different social and professional approaches. No one profession can by and in itself provide the insights, activities, and methods which serve to ameliorate the many problems confronting the aging members of our society which, of course, include our schizophrenic patients; ie, those individuals who develop schizophrenia and reach the senium. The problem is much more complicated and involves social workers, psychologists, physicians, administrators, and religious leaders, as well as psychiatrists. In addition, we must recognize that these patients are subject to all of the physical ailments that affect the nonschizophrenic aged, and special efforts are required to provide adequate diagnostic and therapeutic facilities.

Another added problem in aged schizophrenics is based upon the fact that many of them have been exposed to the use of psychotropic drugs for many years, and this increases the complexities of the management of such patients. In an occasional instance, for example, we find schizophrenics to have had psychosurgery who have continued to require care in the state mental hospitals. It is clear, then, that the total problem of the aged schizophrenic is a complex one which calls for the mobilization of all social facilities, as well as professional facilities in addition to psychiatry, if we are to accomplish adequate handling of the aged schizophrenic.

It is especially important to keep in mind that the effectiveness of practically any of the currently used drugs to modify the behavior of the aging schizophrenic, or for that matter any type of behavior disturbance, is strongly influenced by the actual living conditions affecting the patient. In other words, a patient who is directly involved in a structured environment such as is provided in a nursing home or state hospital may react entirely differently to the same drug regimen when living alone or with his family. On this basis, it is difficult to make any valid conclusion as to adjustment unless one takes into account the idiosyncratic reactions of the aged individual in a specific type of environment.

Muller has done some interesting work in the study of senescence in schizophrenics. In 1959, he evaluated 101 schizophrenics and reported that in about 2% there was evidence of an organic brain syndrome which he considered was consistent with the findings of such an organic brain syndrome in the general population. Subsequently, in 1971, he examined 30 of the patients who were examined in the original series in 1959, the other patients either

having died or having become unavailable for study for other reasons. In these 30 patients he reported that they had been removed from their wards in the mental hospital and had been placed in an annex of the hospital where they received a semimedical orientation, and that this facility was reserved solely for those patients who were 65 years or older.

He reported that 23 of them showed practically no changes during the intervening ten years. He found that in some aging schizophrenics the patient became more feeble, less vigilant, and often less expressive. In five of his 30 patients, he reported that there seems to be an amelioration secondary to involution with somewhat better reality testing and a higher level of activity and a better degree of objectivity to their delusions. However, he tended to emphasize the fact there is little modification of the schizophrenic illness as a result of the aging process, and he felt that the effects of aging on schizophrenia was noted only at the beginning aging process, about the age of 60, and was independent of the degree of "senile dementia."

Table I
Muller's Study (1971) Arizona State Hospital Study (1972)

Mild Mnestic Difficulties Due to Aging Process Considered to be Within Normal Limits	8	4
Relatively Mild Organic Changes Evidenced by Deficits in Recent Memory, Orientation and Personality Changes	4	9
Chronic Brain Syndrome as above, More Advanced	6	5##
Profound Organic Changes, True Senile Dementia with Global Disorientation, etc	9	2#
Status Undetermined Due to Problems in Examination	3	9#
Total	30	29

One patient had lobotomy.

One patient totally blind; however, in our series nine had substantial defects in hearing and/or vision (two had glaucoma).

In our series of 29 schizophrenics who are 65 years or older (see Table I) who have continued to receive care in our State Hospital as a result of screening by our staff, some were considered unsuitable for placement in a nursing home and three or four had been tried in nursing homes but failed to adjust or were returned by the nursing home staff. These 29 patients represent the residuals of a group of over several hundred who have been successfully placed in nursing homes throughout the state.

In contrasting our categories with those reported by Muller, the first two categories of mild and moderate involvement by the aging process are essentially the same; the difference in actual numbers seems related to differences

in the classification process and really do not represent any serious differences. In the last two categories, one group was reported as profoundly impaired due to organic changes, and in the last group were those where the status of their mental reactions could not be evaluated. Our figures apparently are the reverse of those in the Muller group. We found that nine patients were so inaccessible to evaluation that no decision could be made as to the present effects of the aging process on the schizophrenic illness. There are no essential differences in our findings compared to those by Muller. However, it was our feeling that the aging process affected each schizophrenic in an individual way and one could not make a generalization as to the overall effects of the aging process on the schizophrenic process.

The aging process in schizophrenia has reduced the behavioral disturbances sufficiently so that many of our elderly schizophrenics have been able to adjust fairly well in nursing homes. Some schizophrenics, on the other hand, continue to show disturbed behavior which makes their adjustment in a nursing home unusually difficult. There are some cases where inflexibility on the part of the nursing home staff makes it difficult to retain patients who really could live in a

nursing home type of situation, but are sent back to the state hospital where they continue to take up beds which could be put to better use in terms of specific therapy for the mentally ill. The aging process has largely served to minimize the difficulties in adjustment of schizophrenic patients so as to provide an adequate solution for their care in nursing homes without overloading the state hospital system.

Summary

The aging process in schizophrenics tends to reduce the intensity of their reactions and increases their manageability. Many, but not all, elderly schizophrenics can be cared for in nursing homes or even sheltered care homes. In a few cases, bizarre behavior and unpredictability require continued care in a mental hospital. Careful selection is essential to success in placement of the elderly schizophrenic patients. Many nursing homes still lack protected areas where these patients can walk about in the outdoors without being a source of danger to themselves or others.

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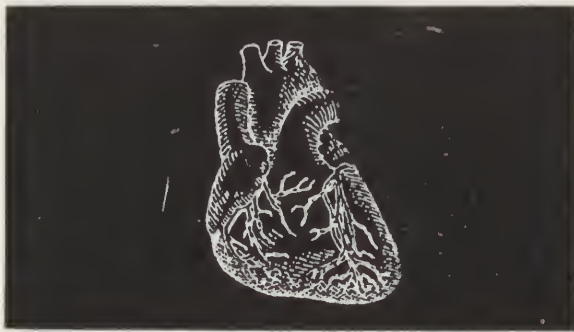
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DANIEL V LINDENSTRUTH MD
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AN OVERVIEW

Positive End Expiratory Pressure (PEEP)

CARMEN FRATTO MD

Dr Fratto is Head, Pulmonary Division, Maryland General Hospital, Baltimore.

Historical Background

The concept of PEEP is not new. In 1938, Barach¹ used what he called continuous positive pressure breathing (CPPB) for the treatment of acute pulmonary edema. This was accomplished without the use of a ventilator by having the patient breathe against a fixed pressure. The method had been abandoned in recent years, apparently because of the development of potent diuretics and rapid acting digitalis preparations.

In 1967, Ashbaugh, Petty et al² reintroduced the concept when they reported a series of 12 patients with the Adult Respiratory Distress Syndrome (ARDS), some of whom were treated with PEEP. Although the series was small, there seemed to be definite clinical benefit and increased survival in the patients treated with positive end expiratory pressure. Since that time, numerous reports have appeared in the literature substantiating the value of this mode of therapy. The use of PEEP has now become well established as an effective means of improving oxygenation of arterial blood in certain well defined circumstances.

In some patients, particularly those with the ARDS, adequate oxygenation can not be maintained with inspired oxygen concentrations as high as 100% delivered by conventional intermittent positive pressure ventilation (IPPV). In a substantial number of these patients adequate oxygenation can be achieved by simply adding 5 to 10 cm of PEEP. Furthermore, there is evidence that prolonged high inspiratory oxygen concentrations may be harmful to the respiratory tract, at times producing the ARDS.³ Recent emphasis has, therefore, been placed on

the use of PEEP in an attempt to maintain arterial oxygen tension at acceptable levels while utilizing inspired oxygen concentrations of less than 50%.⁴

Adult Respiratory Distress Syndrome

The ARDS is characterized by marked respiratory distress, tachypnea, cyanosis, refractory hypoxemia, loss of lung compliance resulting in high inflation pressure requirements during ventilatory support, and diffuse infiltrate on chest X-ray. The alveolar-arterial oxygen gradient is greatly increased; and, while breathing 100% oxygen, the patient may have an arterial oxygen tension well below 100 mm Hg rather than the expected level of approximately 600 mm Hg.

The syndrome often occurs in people with previously normal lungs and in patients without direct lung trauma. It may follow trauma, infection, surgery, shock, fluid overload, sepsis, acidosis, aspiration pneumonitis, viral pneumonia, fat embolism, neurological injuries, pancreatitis, cardio-pulmonary bypass, and prolonged high concentration oxygen therapy. This syndrome has also been known as, or is at least very similar to, the syndromes of shock lung, congestive atelectasis, posttraumatic pulmonary insufficiency, oxygen toxicity, pump lung, respirator lung, and possibly a variety of others including the infant respiratory distress syndrome. This constellation of signs and symptoms encompasses a wide variety of causes and, thus, constitutes a somewhat nonspecific response of the lungs to direct or indirect trauma.

The gross pathological picture in the lungs is that of hepatization. Microscopically, capillary congestion, atelectasis, interstitial edema and intra-alveolar hemorrhage are noted. Hyaline membranes are frequently present.

Increased surface tension and decreased pulmonary surfactant activity are rather consistent postmortem findings. Surfactant is a surface active material which lines normal alveoli and prevents collapse of the alveoli by reducing surface tension as they decrease in size during expiration.^{5, 6}

Indications

Much controversy remains regarding the indications for this procedure and the potential detrimental effect it may have on net oxygen delivery to the tissues. The arterial oxygen tension is not the sole factor. Oxygen delivery depends upon cardiac output as well as arterial oxygen content. Furthermore, oxygen content is dependent upon oxygen tension and the quality and quantity of hemoglobin present. One must not feel secure solely on the basis of an acceptable arterial oxygen tension since oxygen delivery may be greatly diminished with low hemoglobin concentrations, abnormal hemoglobins, or low cardiac output, even in the face of normal or high arterial oxygen tensions.

It has been shown that PEEP may reduce cardiac output in subjects with normal lung compliance. Patients with "stiff" or noncompliant lungs seem to be protected from this effect since the high airway pressures are not well transmitted to the pleural space and, consequently, effect on venous return is generally negligible.

The most frequently agreed upon indication is the ARDS where the lungs are relatively noncompliant and adequate tissue oxygenation can not be maintained in spite of a high concentration of inspired oxygen. Some feel that this modality should be tried on all patients who have severe arterial hypoxemia while receiving high inspired oxygen concentrations whether or not they manifest the full blown ARDS.⁴ One would be well advised, however, to carefully monitor all patients treated in this manner.

Technique and Mode of Action

Intermittent positive pressure ventilation is commonly used to assist or control ventilation in patients with respiratory failure. This is accomplished by the intermittent application of positive pressure to the airways during inspiration, after which airway pressure is allowed to fall to atmospheric level. Thus, airway pressure at end expiration is zero relative to atmospheric pressure. When PEEP is applied, airway pressure is prevented from falling to zero during expiration. This may be accomplished by the use of a commercially available respirator attachment or, less expensively, by constructing an adaptor with materials readily available at any

hospital.⁷ The degree of residual pressure maintained at end expiration is generally 5 to 10 cm of water.

Positive end expiratory pressure probably improves the arterial oxygen tension by preventing airway and alveolar collapse during expiration. This constant distending pressure elevates the functional residual capacity (amount of air or gas in the lungs at end expiration) resulting in ventilation of the lung from a larger lung volume. Alveolar stability is improved with resultant improvement in alveolar ventilation, more favorable ventilation-perfusion relationships and improved arterial oxygenation. Pulmonary congestion and edema may be reduced by the increased interstitial pressure. If the cardiac output remains favorable, improved oxygen delivery results. One should bear in mind the fact that PEEP alone is not the total answer. It does seem to "buy time" while other therapeutic measures aimed at treating potentially reversible precipitating and complicating factors are instituted.^{4, 8, 9}

Adverse Effects

Pneumothorax and decreased cardiac output are the two most frequently reported serious adverse effects. Pneumothorax is most likely to occur in patients who have patchy parenchymal involvement with resultant regional changes in compliance or airway resistance and in those with pulmonary emphysema. A fall in cardiac output may occur in hypovolemic⁴ states or in patients with relatively compliant lungs as previously stated. Ideally, cardiac output should be measured. If this is unavailable, one may obtain meaningful and adequate information from measurement of urine output, peripheral arterial blood pressure, and arterial and mixed venous blood gas analysis. Danger signals include a decrease in urine output, significant systemic hypotension, or a fall in mixed venous oxygen tension, particularly if this was low prior to institution of PEEP.⁸ Conversely, a large rise in arterial oxygen tension, an increase in a previously low mixed venous oxygen tension, and improved urine flow are relatively good prognostic signs.

Results

In most series the mortality rate is somewhat greater than 50% in PEEP-treated patients. Without a large, well-controlled series, one can only speculate on the basis of available studies that the mortality rate in similar non-PEEP-treated patients would be significantly higher. Prognosis is also related to the etiology of the respiratory failure. In a series of 36 such patients treated in this manner, Nicotra et al⁸ noted a much

higher survival rate in patients with respiratory failure following cardiovascular surgery than in those with respiratory failure due to other causes. It is also interesting to note that this type of therapy has been used for treatment of the infant RDS with encouraging results.^{10, 11}

Summary

Positive end expiratory pressure is an effective means of therapy in some patients with severe refractory hypoxemia, particularly those with the adult and infant respiratory distress syndromes. When properly used, the results can be dramatic and lifesaving. With improper use and without careful monitoring the results can be equally adverse. A prerequisite to the use of PEEP would, therefore, be an in-depth understanding of all aspects of this mode of therapy.

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Scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians and medical institutions who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held at the Baltimore Civic Center on

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Ample space is available; however, it is suggested that applications be submitted as soon as possible.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
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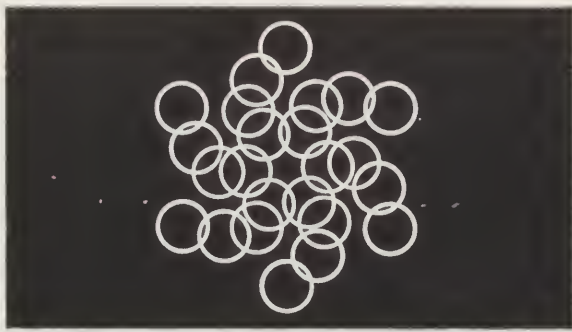
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5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed ONE inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
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From the Subcommittee on Alcoholism of the
Medical and Chirurgical Faculty of the State
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alcoholism section

TRAINING PROFESSIONALS FOR MEETING THE NEEDS OF ALCOHOLICS AND PROBLEM DRINKERS

WILLEM G A BOSMA MD

Dr Bosma is Director, Alcoholism and Drug Abuse Programs, University of Maryland Medical School, Baltimore.

Continued from October

Education and Training

I have dealt extensively with the services at University Hospital because the foundation for an adequate education and training program in alcoholism lies in an adequate and comprehensive treatment program. This is a new and complex field in which new approaches are necessary. Conventional educational models are incomplete or not relevant. So-called, on-the-job training is often worth many lectures or discussions in alcoholism education.

Two years ago, due to the interest of the staff of the Institute of Psychiatry and Human Behavior of the University of Maryland, an interdisciplinary program of alcoholism was initiated at the Baltimore campus of the University of Maryland. This encompasses the schools of Medicine, Social Work, Nursing, Pharmacy, Law, and Dentistry. It was felt, that to come to terms with one of the major medical and social problems in the country, the cooperation of professionals in every field was mandatory. This is a community problem requiring the services of the whole community. Whereas it may not be possible to change the prejudices, apprehensions, and misunderstandings of many of the old hands about alcoholism, it is highly desirable to train the professions of tomorrow. The first effort was to introduce some facts about alcoholism to all the schools through conventional lectures. The enormous size of the enrollment made this impractical; now, each school is handled separately.

At the same time, the various schools were encouraged to introduce alcoholism into their own

curricula as seen from their respective viewpoints. In a recent survey, however, we found that in the medical school, not one department except the Department of Psychiatry devoted any time to alcoholism; neither did the schools of Law, Social Work, and Nursing. Pharmacy and Dentistry offered a few perfunctory lectures, mainly because one of the faculty members was interested in the problem. On the other hand, some aides and so-called lower echelon people at the hospital have indicated an interest in learning more about alcoholism.

Alcoholic services the hospital has been providing are the main factor in some of the schools' slowly changing their attitudes about alcoholism education. Alcoholism personnel have slowly been accepted as members of treatment teams and their advice is sought more and more frequently. They stimulated interest to such a degree that inservice training was requested. In one year, 12 different courses were conducted with students, including nurses and the campus police. This led to occasional disputes with the attending doctors. Heated discussions ensued between the medical students, residents, and attending physicians, so that the director of alcoholic services was called to arbitrate. As a result, grand rounds on alcoholism were conducted at the request of the chief residents.

When alcoholism services in the Emergency Room were threatened, the medical students in this service appealed to the dean.

Another sign of improvement (that is, of a change of attitude) is indicated by the more frequent primary or secondary diagnosis of alcoholism in the hospital.

Apart from basic lectures given to most of the schools on the campus, which give some basic facts and try to stimulate interest, the

curriculum consists of seminars with field experience, or clinical experience. As our services are not capable of absorbing such large numbers of students, the latter go out to the clinics, alcoholism services in health departments, and State hospitals in the city and surrounding county.

Twenty-six courses on alcoholism were offered last year. One thing discovered at the beginning was that it was impossible to separate alcoholism from the overall field of addictions and drug abuse. The students found it logical and imperative that the whole realm of addictions be covered in the seminars. The high incidence of drug abuse among the children of alcoholics was an issue, as was the mixed addictions with alcohol one of the addictive substances.

Four representative courses were:

I. Interdisciplinary Course for Schools of Social Work and Nursing (3 credits). Course Outline—Eight seminars consisting of the following:

1) Drinking practices in American society: Historic overview of drinking practices in this country; the temperance movement and its impact; control legislation; conflicting guidelines as to whether to drink or not, and when, where, what, with whom, how much to drink; alcohol problems, with special emphasis on youth and traffic safety, etc.

2) The disease process: Beginning with the first drink, or after 20 years of social drinking; early symptoms—physical, psychological and social, development of denial systems; effect on behavior at home, in traffic, on the job; effect on spouse and children, and their reaction development; impact on social agencies; how to identify the alcoholic in the early stages, how to avoid stereotyping, etc.

3) Public and professional attitudes toward alcoholics and their treatment: Negative attitudes arising from personal prejudice or problems and misinformation or lack of information, and pessimism because of treatment results, etc.

4) A comprehensive alcoholism program and the role of nurses and social workers: The Maryland Law and programs; the interrelationships between social workers and nonprofessional counselors in regard to helping the alcoholic individuals and their families, etc.

5) How to help alcoholics and their families: Ten Commandments for Helping the Alcoholic.

6) Drug abuse in America: A general overview of the problem.

7) Drug abuse—the disease process: Psycho-

logical, physiological and sociological aspects of drug abuse; how abuse of other drugs relates to alcoholism; cross addictions, etc.

8) How to help drug abusers and their families: an indication of the role of the nurse and social worker in the treatment process.

Each seminar is held for two hours.

Field placements—Field work is dependent on the individual needs and requirements of students and ranges from one half day per week to a whole day per week, with selections made from the following:

- 1) University Hospital and Clinics
- 2) Tuerk House and Alpha House (the male and female quarterway houses)
- 3) Baltimore Alcoholism Center
- 4) State Hospital Alcoholism Rehabilitation Units

5) Sinai Hospital Drug Program

6) Johns Hopkins Addiction Programs

In addition to field placements, supervised field trips to a variety of specialized resources are made.

Case presentations—From sessions 9 through 15, each student is responsible for the discussion of the results of their field work, including a case presentation. A required and optional reading list is included.

II. Interdisciplinary teams—This seminar includes students from six professional schools on the Baltimore campus of the University of Maryland. They are divided into teams composed of one representative from each school. Each team is assigned to a clinical facility where its members evaluate and work with at least one alcoholic and one drug abuser. Each student uses his specialized knowledge to contribute to the treatment program. In addition to field work, there are eight weekly seminars consisting of three introductory presentations encompassing the basic facts and the logistics of teamwork with addicts and their families. During the last five seminars, the teams present their experiences and focus on the importance of involvement of each one of the disciplines, integration of the different approaches to the patients, and understanding their respective attitudes. There is a required reading list.

III. Emergency Room (interdisciplinary)—This clinically oriented inservice training program includes students from the schools of nursing and medicine. It trains them in management of acute clinical stages of alcoholism in an emergency room, as well as teaching to make appropriate referrals to outside services. The students are assigned, by rotation, to seven

days a week on the evening shift. Initially, this group receives orientation covering basic facts on alcoholism and is provided individual and group supervision throughout, along with field trips to local rehabilitation facilities and social agencies.

IV. Quarterway house for men—This training program is for male students from the schools of Nursing, Medicine, Social Work, and Dentistry. They regularly spend the night from 7:30 PM to 7:30 AM, at the quarterway house. They are assigned for one semester on a rotation basis so they will be exposed to activities scheduled on different days of the week. The students are involved in administration, evaluation, group and individual therapy, family counseling, discharge planning, and follow-up. They are actively involved throughout in educational and supervisory seminars, as well as personal supervision and field trips to local rehabilitation facilities and social agencies helpful with the rehabilitation effort. A similar program for female students is available at the women's quarterway house.

In the outline of Courses I and II, the emphasis appears to be on the seminars. However, for every two hours of seminars at least four hours of field placement and one hour of supervision are included. Many students spend much more time at their assignments, working side by side with alcoholism counselors. It was the intention from the beginning that the students should learn most from the patients and the counselors. Mainly, the seminars were discussions to help students place their experiences in perspective, provide some structure, and help them overcome difficulties in their interactions with patients, agencies, and fellow workers. The interdisciplinary seminars and the team work affirmed the complexity of the problems associated with alcoholism. They also proved that all professionals can work together fruitfully.

One interesting sidelight of interdisciplinary education was how the initially different approaches and attitudes of the various professions were resolved. The social work students were at first rather hesitant and passive, quite contrary to the medical and nursing students. Attitudes towards, and methods of working with, the alcoholic and drug abuser changed markedly under the influence of the group, as did the initial differences of opinions and attitudes of the student group. These students will have no difficulty knowing in what areas the other professions are most helpful, nor will they be hesitant to seek out other professionals for help.

One unmentioned aspect of the educational program is training in group therapy. All the group sessions conducted at University Hospital allow visitors and observers. Tuerk Clinic, for example, is held every Saturday morning. Because of the interest of students from the professional schools on the campus and the attendance of alcoholism professionals from the outside of this complex, an educational meeting is held after the group therapy session, in which group process and group therapy techniques are discussed. This meeting is generally attended by six to ten professionals and students.

Certainly this type of group experience for residents in psychiatry and social work students is essential if they are going to treat alcoholics. Not all alcoholics feel comfortable at AA meetings, yet thrive in group therapy. A training program is being prepared in this area. The plan is for the psychiatric resident and interested social worker to be a cotherapist on one group for a few months and then to conduct their own group under supervision for at least six months. A few residents are already involved in group work.

Alcoholism Counselor Traits

Finally, it remains to discuss the type of person who works comfortably and effectively with an alcoholic. Until recently, it was as difficult to assess the potential effectiveness of an alcoholic worker as it was of a worker in any profession where human interaction was involved. The main criterion for judging a potential employee has been his expressed interest in the alcoholic, generally considered a difficult and frustrating patient. The final judgment of effectiveness was the individual's on-the-job performance. Studies since 1960, however, have indicated that there are measurable qualities in high-functioning helpers which could result in a high measure of predictability in hiring effective workers. For the following data, I am particularly indebted to Sidney Wolf PhD, Chief, Division of Alcohol Abuse and Alcoholism, Baltimore County Department of Health.

Since 1960, studies have indicated that there are some individuals who are particularly gifted in working with other people and there are others who are incompetent or even destructive in their efforts to help (Carkhuff, 1969). "Treated" individuals received extreme scores on criterion measures of improvement, compared with "untreated" individuals whose condition remained basically the same. Under treatment, some patients improved, whereas the conditions of others even deteriorated. Further studies in-

licated that the therapists were responsible for these variations in improvement (Traux and Carkhuff, 1967).

Carkhuff and Berenson (1967) conducted research to contrast effective versus ineffective treatment personnel. They discovered a number of traits which enabled a person to be an effective "helper." When the helper did not possess these traits, his efforts were destructive to the patient's condition. These traits were found to be independent of the "helper's" role, his specific discipline—psychiatry, psychology, social work, etc—his function, or even of his theoretical orientation.

Carkhuff (1969) indicated that these traits can be measured reliably. The following traits were isolated and measured, and were found to be present in a high-functioning "helper":

Empathy (Carkhuff, 1969)—The ability to understand another person's feelings and enumerate them.

Respect—The ability to appreciate the intrinsic dignity, uniqueness and worth of another human being.

Genuineness (Carkhuff, 1969)—The ability of an individual to be himself, there being no discrepancy between what is said and what is felt.

Concreteness (Carkhuff, 1969)—The ability to stick to the issues at hand.

Confrontation (Berenson, Mitchell and Taney, 1969)—The ability to assess discrepancies between verbal and nonverbal communication and to confront the patient with them.

Self-disclosure (Carkhuff, 1969)—The ability to reveal pertinent personal data for the benefit of the patient rather than remain behind a screen of neutrality.

Immediacy (Collingwood and Reis, 1969)—The ability to make sense of the patient-therapist's present, ongoing relationship.

Potency (Wolf, 1970)—The dynamism of the therapist, the sense of presence communicated to the patient.

Self-actualization—This trait, more than most, is important to success in therapy (Foulds, 1969). The self-fulfilled therapist presents the best model for a patient.

The possession of all these traits does not necessarily imply a superman, but does imply a high-functioning helper, who has a high percentage of success in helping his clients. The use of the tests to measure these traits should result in improved efficiency in determining who is or is not well-equipped to treat the alcoholic (Wolf, 1972).

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Occasionally, I use my lunch period to browse in nearby book shops. Among my hobbies is a collection of books on mountaineering, and I have come across some fine items in Baltimore.

Recently, on one such occasion, I found two copies of John Tyndall's *Hours of Exercise in the Alps*. John Tyndall's writings helped popularize the sport of mountaineering in the Alps during the last half of the 19th century. The books themselves were not rare. They were 1898 American editions. The first edition appeared in England in the 1870s. But one of the copies had Harry Friedenwald's book plate inside the front cover (see accompanying reproduction). On the title page was Dr Harry Friedenwald's autograph, and the words, "vacation, 1903."

Dr Friedenwald was a well-known Baltimore ophthalmologist. He was a member of the Medical and Chirurgical Faculty until his death in 1950. He served as President of the Faculty in 1923. The Faculty's library owns many of Dr Friedenwald's medical books and papers. The historical collection houses several of his journals and diaries.

Further examination of this book revealed maps and train schedules that had been clipped from an itinerary and inserted at appropriate places in the book. Several maps had notes in Dr Friedenwald's handwriting. On a map showing the Matterhorn, a route was penciled in, and the word *ascent*. Because of my association with the Medical and Chirurgical Faculty, and being an active climber myself, this book has become one of the more prized items in my collection on mountaineering.

Assistant Librarian JOSEPH E JENSEN

* * *

MEDLINE NEWS

In August we ran 159 searches through our MEDLINE terminal, the requests varying from



"Bullet embolism from gunshot wound to the heart" to "vulvar hematoma" to cataloging through CATLINE and checking serial holdings on SERLINE. On Aug 20, NLM began charging for on-line time; for the time being, we will not be passing this charge on to the requester. You may, however, receive a note informing you of the amount a search *would* have cost you if we charged. This does not, of course, include the manpower cost or the paper cost—only the NLM charge to us.

* * *

New Accessions List

We urge all readers to peruse our accessions list, since lately we have been adding some very timely and significant titles. As we can't possibly notify each Med-Chi member of new books in his or her specialty, we take this means of keeping you informed. Any book on this list, except those classified in *Reference* may be borrowed by members. Give us a call, a card, or, better yet, come by and select the books you need. There's nothing equal to browsing for discovering the very titles you need.

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NEW ACCESSIONS — BOOKS (Arranged by Subjects)

ANATOMY

- QS Grant, John Charles Boileau
17 **An atlas of anatomy, by regions**, 6th ed. Balti-
.G7 more, Williams & Wilkins, 1972

BIOCHEMISTRY

- QD Symposium on Carbon-Fluorine Compounds:
412 Chemistry, Biochemistry and Biological Ac-
.F1 tivities. London, 1971
.S9 **Carbon-fluorine compounds**; chemistry, bio-
chemistry & biological activities; a Ciba
Foundation symposium. Amsterdam, New
York, Associated Scientific Publishers, 1972

BIOLOGY

- QH Lengerova, Alena
315 **Immunogenetics of tissue transplantation**. Am-
.L4 sterdam, North-Holland Pub Co, 1969

CARDIOVASCULAR SYSTEM

- WG Marriott, Henry Joseph Liewellyn
140 **Practical electrocardiography**, 5th ed. Balti-
.M3 more, Williams & Wilkins, 1972
WG **Vascular smooth muscle**. Proceedings of the
101 satellite-symposium of the XXV International
.V2 Congress of Physiological Sciences and An-
nual Meeting of the German Angiological
Society, July 20-24, 1971 in Tubinger. Edi-
tor: E Betz. New York, Springer-Verlag,
1972

CENTRAL NERVOUS SYSTEM

- WL Anderson, Camilla May
340 **Society pays; the high costs of minimal brain**
.A5 **damage**. New York, Walker, 1972

CHILDREN'S DISEASES

- WS Kirman, Brian Herbert
107 **The mentally handicapped child**. London, Nel-
.K5 son, 1972
WS Smith, Clement Andrew
200 **The critically ill child**: diagnosis and manage-
.S6 ment. Philadelphia, Saunders, 1972

GERIATRICS

- WT **The Relation of aging to immunity**; papers by
104 R L Walford et al. New York, MSS Infor-
.R4 mation Corp, 1973

GYNECOLOGY

- HQ Draper, Elizabeth
766 **Birth control in the modern world**—the role of
.D7 the individual in population control, 2d ed.
Baltimore, Penquin Books, 1972
WP Haller, Jurgen
540 **Hormonal contraception**. Los Altos Calif,
.H2 Geron-X, 1972
QV **The Pill**: biochemical consequences. Sympo-
177 sium organized by the Association of Clinical
.P5 Pathologists and the Assoc of Clinical Bio-
chemists, delivered in London on 27 Sept
1969. London, British Medical Assoc, 1969

HOSPITAL ADMINISTRATION

- WX King, Charles M
179 **Drug information services; two operational**
.K5 **models.** Model I: A complete drug informa-
tion service in a hospital. Model II: A re-
gional drug information service network.
Rockville Md, Pharmacy-related programs
branch, National Center for Health Services
Research & Development, 1972

MALE GENITALIA

- WJ **Vasectomy:** current research in male steriliza-
780 tion. Papers by Frederick J Ziegler et al.
.V3 New York, MSS Information Corp, 1973

MEDICINE

- W **Allied Health Education Programs in Senior**
22 **Colleges.** Bethesda Md, US Div of Allied
.AA1 Health Manpower, 1971
.A3
W American Medical Association. Dept. of Allied
22 Medical Professions and Services
.AA1 **Educational programs for the physicians' assist-**
.A5 **ant.** Chicago, 1973
WB Conference on Quality Assurance of Medical
50 Care, St Louis, 1973
.AA1 **Quality assurance of medical care;** monograph.
.C6 Rockville Md, Health Service and Mental
Health Administration, 1973
W Fendall, N R E
21.5 **Auxiliaries in health care; programs in develop-**
.F3 **ing countries.** Baltimore, published for the
Josiah Macy Jr Foundation by the Johns
Hopkins Press, 1972
W **Selected papers from a seminar on automation**
26.5 **in medicine.**
.S4 Sponsored by Cedars of Lebanon Hospital,
Miami Fla. Mount Kisco NY, Futura Pub
Co, 1973
W Student American Medical Association. Joint
18 Commission on Medical Education.
.S9 **A handbook for change;** recommendations of
the Joint Commission on Medical Educa-
tion. Rolling Meadows Ill, Student American
Medical Association, 1973

NERVOUS SYSTEM

- WL **The Chemistry of mood, motivation, and**
104 **memory;** the proceedings of an interdisciplin-
.C5 ary conference on the chemistry of mood,
motivation, and memory held at the Univ of
California, San Francisco, in Oct 1971. New
York, Plenum Press, 1972
WL Group of European Nutritionists.
102 **Nutrition and nervous system;** proceedings of
.G85 the ninth symposium of the Group of Euro-
pean Nutritionists, Chianciano, May 1970.
New York, Karger, 1972
WL Handa, Jyoji
141 **Dynamic aspects of brain scanning.** Baltimore,
.H2 University Park Press, 1972

OPHTHALMOLOGY

- WW Perkins, Edward Sylvester
17 **An atlas of diseases of the eye,** 2nd ed. Edin-
.P4 burgh, Churchill Livingstone, 1971

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PATHOLOGY

- QZ 140 .C7 Conference on Shock, Glasgow, 1970
Conference on shock; proceedings of a conference held at the Royal College of Physicians and Surgeons of Glasgow, 22-23 Oct 1970. London, Kimpton, 1972
- QZ 200 .R1 Radiotherapy Symposium, 5th, Miami Fla, 1971
Clinical pediatric oncology; research, diagnosis, treatment, and prognosis of malignant tumors of childhood. Mount Kisco NY, Futura Pub Co, 1972
- QZ 206 .T3 Fenovus Workshop, 4th, Cardiff, Wales, 1972
Prolactin and carcinogenesis; proceedings . . . March 1972. Cardiff, Wales, Alpha Omega Alpha Pub, 1972

PERIPHERAL VASCULAR DISEASES

- WG 500 .E8 European Association of Radiology.
Angiography/scintigraphy. New York, Springer-Verlag, 1972
- WG 550 .I6 Interdisciplinary Conference on Fundamental Data on Reactions of Vascular Tissue in Man, Lindau Germany, 1970. **The artery and the process of arteriosclerosis**; proceedings. Edited by Stewart Wolf. New York, Plenum Press, 1971-72

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- WM 460 .B2 Balint, Michael
Focal psychotherapy, an example of applied psychoanalysis. Philadelphia, Lippincott, 1972
- WM 270 .C4m Chambers, Carl D
Methadone. New York, Behavioral Publications, 1973
- WM 276 .T6 Johnson, Bruce D
Marilnana users and drug subcultures. New York, Wiley, 1973
- WM 270 .M1 McLean, Gordon R
High on the campus. Wheaton Ill, Tyndale House Publishers, 1970.
- WM 420 .M2 Mann, James
Time-limited psychotherapy. Cambridge Mass, Harvard Univ Press, 1973
- WM 460 .R8 Rubins, Jack L
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- WM 203 .S9 Study group on infantile autism, London, 1970.
Infantile autism: concepts, characteristics, and treatment. Edinburg, Churchill Livingstone, 1971

PUBLIC HEALTH

- WA 300 .C7 Conference on Nutrition, Growth, and Development of North American Indian Children, University of Oklahoma, 1969. **Nutrition, growth and development of North American Indian children** US GPO, 1972
- WA 22 .AA1 .I6 Inventory of Federal programs that support health manpower training. 1970- . Bethesda Md, National Clearinghouse for Health Manpower Information. US GPO, 1970.

- WA 240 .M8 **The Mutagenicity of pesticides: concepts and evaluation**. Cambridge Mass, MIT Press, 1971
- WA 670 .R8 Rothman, Harry
Murderous providence. Indianapolis, Bobbs-Merrill, 1972

THERAPEUTICS

- WB 342 .B9 Bryan, Clifford D
Manual of respiratory therapy. St Louis, Mosby, 1973
- WB 930 .I7 **Index medicus homeopathicus cumulativus. 1958-** . Philadelphia, American Institute of Homeopathy

TRAUMATIC SURGERY

- WO 700 .P3 **The Pathology of trauma: symposium organized by the Royal College of Pathologists and delivered in London in Feb 1970**. Published for the Royal College of Pathologists by the Journal of Clinical Pathology, 1970

HISTORY OF MEDICINE

- WZ 80 .K2 Kagan, Solomon Robert
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- WZ 56 .K5 King, Lester Snow
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- W 20.9 .M35s Medical Society of the County of Kings. Sesquicentennial Journal, 1822-1972. Brooklyn, 1972
- W 26 .M6 Mitchell, Silas Weir
The early history of instrumental precision in medicine. New York, B Franklin, 1972
- WZ 100 .R9 Rusk, Howard A
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- Z 665 .S7 Special Libraries Association. San Francisco Bay Region Chapter
The library. New York, Special Libraries Association, 1967



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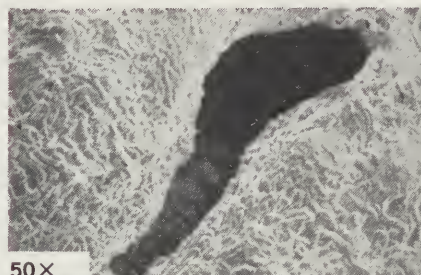
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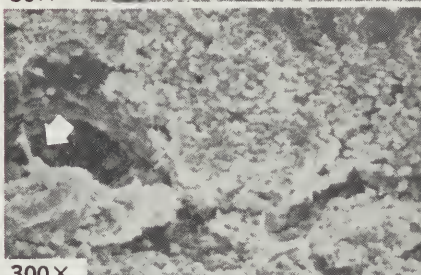
Progress in Diagnosis

In these illustrations of tissue from a patient with acute cystitis, you can see the swollen and inflamed mucosa of the ureteral orifice (50X), a fibrin strand (300X), and a whitish exudate composed of polymorphonuclear leukocytes (1000X and 3000X). The photographs were taken with the scanning electron microscope (SEM) by Dr. Shirley Siew, Associate Professor of Pathology at the University of Pittsburgh School of Medicine. They come from the clinical exhibit "Scanning Electron Microscopy of Urinary Tract Infection," which won first prize in Clinical Research at the May 1972 meeting of the American Urological Association.

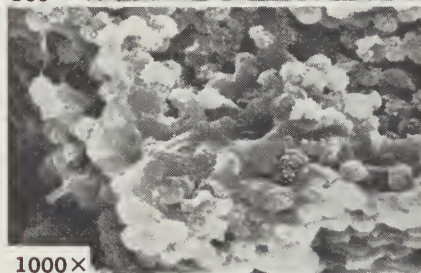
The scanning electron microscope promises to be extremely useful in its investigation of human pathology. In time, examination of tissue with the SEM is likely to play a significant role in the diagnosis of urinary tract infection.



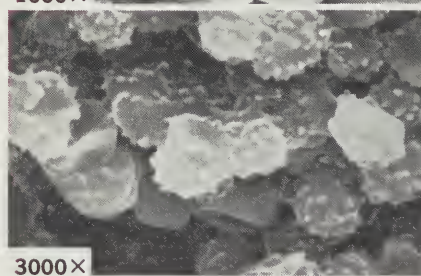
50X



300X



1000X



3000X

A note on the photography:

These photographs were made by the scanning electron microscope, which, like the transmission electron microscope, operates on the basic principle of exposure of tissue to a beam of electrons in a vacuum. With the SEM, electrons bombard the surface of tissue which has been given a fine coating of gold. The electrons reflect off the tissue onto a television screen, and the resulting photograph shows a three-dimensional effect. The tissue sections need not be ultrathin, so there is a minimum of handling and distortion.

Just as much an instrument of progress and just as helpful in its way has been Gantrisin (sulfisoxazole) Roche, developed and introduced a generation ago. However, there's been no generation gap over its continuing usefulness. In fact, Gantrisin, with so many years of clinical experience behind it, is still one of the most valuable drugs we have for the treatment of non-obstructed cystitis, pyelitis or pyelonephritis due to susceptible organisms such as *E. coli*. Specifically, Gantrisin provides your patient with certain important therapeutic advantages:

References: 1. Bran, J. L.; Karl, D. M., and Kaye, D.: *Clin. Pharmacol. Ther.*, 12:525, 1971. 2. Burke, E. C., and Stickler, G. B.: *Mayo Clin. Proc.*, 44:318, 1969. 3. Hibbard, L. T., in Bulger, M. J., et al.: *Patient Care*, 1:(3) 47, 1967. 4. Holloway, W. J.; Furlong, J. H., and Scott, E. G.: *J. Urol.*, 102:249, 1969. 5. House, T. E., et al.: *Obstet. Gynecol.*, 34:670, 1969. 6. Lampe, W. T.: *J. Am. Geriatr. Soc.*, 16:798, 1968. 7. Moffat, N. A., and Wenzel, F. J.: *Curr. Ther. Res.*, 13:286, 1971. 8. Normand, I. C. S.: *Practitioner*, 204:91, 1970. 9. Pryles, C. V.: *Med. Clin. North Am.*, 54:1077, 1970. 10. Seneca, H.; Peer, P., and Warren, B.: *J. Urol.*, 99:337, 1968. 11. Trafton, H. M., and Lind, H. E.: *J. Urol.*, 101:392, 1969. 12. Cohen, M.: *Pediatrics*, 50:271, 1972.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms.

IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml;

measure levels as variations may occur.

Contraindications: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

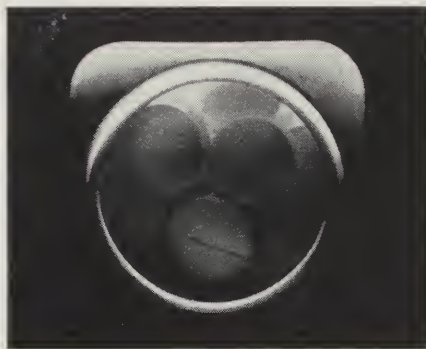
Warnings: Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic

acute cystitis:

Treatment

high urinary levels As a urinary antibacterial, Gantrisin (sulfisoxazole) offers your patients important advantages. Therapeutic urinary and plasma concentrations are usually reached in from 2 to 3 hours and can be maintained on the recommended 4 to 8 Gm/day dosage schedule that's convenient for almost all patients.

generally good tolerance Gantrisin causes relatively few undesirable reactions, and serious toxic reactions are rare. Minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. Hence, Gantrisin may usually be given even for extended periods when treating chronic or recurrent nonobstructed cystitis, pyelitis or pyelonephritis due to *E. coli* and other susceptible organisms. (See Important Note in summary of prod-



uct information.) Complete blood counts and urinalyses, with careful microscopic examination, should be performed frequently.

high solubility Gantrisin (sulfisoxazole) Roche is one of the most soluble of all sulfonamides, with both free and acetylated forms highly soluble in the commonly encountered urinary pH range of 5.5 to 6.5. Urine levels have been detected in

60 minutes; therapeutic levels are usually reached in from 2 to 3 hours. About 90% of a single dose is excreted in 24 to 48 hours. As with all sulfonamides, adequate fluid intake must be maintained.

economy Average cost of therapy is still only about 6½¢ per tablet.

total therapy: 14 days Recent evidence in the medical literature suggests that therapy in acute non-obstructed urinary tract infections should be continued for 10 to 14 days even if patients become asymptomatic in 2 or 3 days, as they often do.¹⁻¹¹ However, one investigator, evaluating a 5-year study of sulfisoxazole used to treat urinary tract infection in 368 girls, found no advantage in continuing therapy more than two weeks *for a first infection*.¹²

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examination should be performed frequently.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* Erythema multiforme (Stevens-Johnson

syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due

to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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EDITORIAL

WHY I'M FINALLY JOINING THE AMA

MICHAEL J HALBERSTAM MD
Internist
Washington DC

"I've changed some, the AMA has changed some, and the problems we all have to face together have changed enormously," says the author in explaining why he became a member.

I have been in private practice for eight years now and have never been a dues-paying member of the AMA. In my opinion it's a clumsy, outdated cross between a trade union and a tissue review committee. I'm joining it today.

Why would anyone pay \$110 a year for the privilege of belonging to an outfit he considers anachronistic and not particularly representative of his views? The answer is that I've changed some, the AMA has changed some, and the problems we all have to face together have changed enormously.

My initial distaste for the AMA came from that strongest of influences, my family. From childhood on I listened to my surgeon-father and GP-uncle swapping medical stories and damning the AMA. Liberals both, they felt that the association was a reactionary dinosaur fighting against good medical care (I think they were correct). As some kids hear sea stories or legends of the pioneers, I heard how the AMA had fought Blue Shield and tried to stop the prepay Group Health Association in Washington.

Nothing I learned in college or medical school disabused me of this bias. I was an idealistic student when the AMA mounted its multi-million-dollar public relations campaign against Harry Truman's medical-care bill, and though I didn't like the bill, the campaign was even worse. The monolithic power of the AMA won, as it usually did in those days.

By the time I started my own practice in 1964, things had changed. The King-Anderson bill had become law over the AMA's objections. In my practice I saw that the concept of the AMA as an all-powerful guild was no longer accurate. Doctors danced to the tunes set by their specialty societies, their hospitals, and their local medical societies, and they couldn't have cared less what the people at 535 N Dearborn St in Chicago were doing.

Clearly, the liberal journalists and reformers who continued to bark after the AMA as the dominant source of America's medical problems were mired in the rhetoric of the 1930s, '40s, and '50s. The AMA that they blamed for everything from low numbers of medical students to high infant mortality rates was now a paper tiger. Such observers of the medical radicals became aware of this. In their analysis of the situation, the nation's health problems stemmed from the fact that medical care had been taken over by a "medical-industrial complex" in which the stakes were hundreds of millions of dollars in construction contracts, equipment purchases, and fat HEW grants.

I agreed with much of this analysis and was pleased to see it get some circulation. Then a funny thing happened. I began to feel sorry for the AMA. And then, of course, I started to think seriously about joining it.

It wasn't merely pity or sympathy for the underdog that made many of us revise our thinking about the AMA. The very factors that had combined to make it an underdog were instrumental in making it a more acceptable organization.

One significant change is that the AMA is being increasingly harried by political opposition within medicine itself. Such groups as the Association of American Physicians and Surgeons and the Congress of County Medical Societies attack the AMA from the right, and are gaining strength. That growing numbers of American doctors consider the AMA to be a left-wing sellout to the Federal Government was unknown to me until some of my articles attracted the attention of conservative physicians. I then found myself addressing the national meeting of one of these groups, and discovered a well-organized body of dedicated, intelligent men. I admired their intensity and conviction. But many of their basic political premises turned me off.

Nor could I and many other "young" physicians join the growing left-wing movement in medicine, as exemplified by the Medical Committee for Human Rights and Physicians for Social Responsibility. These and other groups

had strong representation in Eastern cities, and some of my friends belonged. Agreeing with many of their goals, I was put off by their pre-cut rhetoric and their inclination to take on every nonmedical social problem in sight. Even their views on medical matters, while good-hearted, were naive. Many members had never practiced in the community, but were full-time employes of universities or the Government. I decided to work with them on specific projects—free clinics, draft counseling—but to forgo membership.

Thus, in the politics of medical care, I was a man without a country. Up to this point, the dilemma had never bothered me. I had rationalized that avoiding membership in any medical organization left me free to write articles without being accused of bias.

But the little stirrings of sympathy for the AMA made me re-examine this position. One of the main objections to the AMA among liberal doctors had been its power. There had been something obscene about a professional group that so completely dominated not only its own profession but all the outreaches of medical care. This was no longer so. The AMA now competes not only with other groups inside medicine but with the American Hospital Association and the American Public Health Association.

Moreover, the enormous power to control the practice of medicine once held by the AMA had shifted to the Federal Government. To any liberal or conservative nervous about the concentration of power in a single institution, it has become clear that the Government's influence in medical care must be balanced by a countervailing force—which only the AMA could provide.

Earlier I believed that the specialty societies had made the AMA obsolete. In some ways this is true—the AMA's conventions will never again have the scientific impact they once had and may eventually wither away. But as I reflected on American history and medical politics, it grew ever clearer that the more important the specialty societies become, the more essential it is to have a single group representing all physicians. As impressed as I am by the leadership in my own specialty's socioeconomic arm, I'm sure the American Society of Internal Medicine can't bargain in Congress the way the AMA can.

The crux is that the AMA has changed, and so have I. I've seen some of the warnings of "reactionary" doctors come true—for example,

the Federal subsidy of medical education is already being advanced as a justification for letting the Government tell doctors where to practice. My own "delivery of medical care" is now hindered by a cobweb of FDA rules about telephone prescriptions, verboten medicines, and trial samples. Like many liberals, I think the Government's automatic attempt to solve problems by passing laws and imposing regulations has become counterproductive. The Government can and should protect the innocent, but only God can keep damn fools from acting like damn fools.

The acceptance by liberals of limits on Government intervention has been matched by their acceptance of some intervention by the AMA. Indeed, this is what its right-wing critics find so maddening. The AMA's stated policies are now consistent with the social philosophy of what might be called moderate Democrats and "Eastern" Republicans. The thunder about socialized medicine no longer comes from Chicago, but from the AAPS and other conservative groups.

In the confrontation between the AMA and Senator Kennedy, it seems obvious that the name-calling and the political power plays have come from the latter, not the former. Far from opposing prepaid medicine, the AMA concedes that it is a perfectly valid way to practice.

There are some things that only the AMA can do. Only it can drive home the single reform that would provide the greatest improvement in medical care for the least money—periodic relicensing and recertification. This would not only give the patient assurance of a reasonably up-to-date physician, but, done voluntarily, would put medicine a quantum leap ahead of other professions and occupations in self-regulations.

Most important, only the AMA can speak to the Congress and the people as the voice of medicine. To do this properly and to escape the justified charges that it has been overly representative of older, conservative, small-town doctors, the AMA must reform itself. It might begin by doing what Congress itself does—allow dissenting members to state their views on certain public issues in an official minority report. This would not invalidate the idea of "staying together," any more than a 5-to-4 Supreme Court vote is less valid than a 9-to-0 decision. Trying to preserve the myth of physician unanimity has led to a feeling of despair among dissenting members that their views would ever be reflected in AMA policy.

Nationwide referendums on key issues should be taken regularly among AMA members. Electronic tabulators could enable local and state societies to poll their entire memberships, and the results would be available the next morning. What better way to end charges that the AMA is inflexible, its House of Delegates unresponsive?

I'm aware that such influential physicians as George Himler and Wesley Hall have banged their heads against the AMA hierarchy, which doesn't appear to have bent, much less cracked. But the early history of the AMA shows that for many years it was a progressive, reforming group, particularly when it had a strong cadre of academic physicians taking active part. As academic medicine diverged from practice, the reformers within the AMA became weaker and weaker. Recent small-scale local rebellions show that youthful and academic doctors will join medical societies if the issues are pressing enough. Too often, however, such efforts are a temporary ballot-stuffing maneuver, with the "reform" element dropping out as soon as the critical issue is settled.

I'm encouraged by what I've read about last year's AMA convention in San Francisco. The inclusion of a voting medical student within the House of Delegates may be tokenism, but tokenism often precedes genuine reform. The increasing encouragement of intern-resident membership was evident at San Francisco and should be continued. A special attempt should also be made to reinterest academic physicians in the day-to-day work of the AMA.

I liked the valedictory by Dr Hall and the salutation by Dr Hoffman, though I disagreed with parts of each. I was encouraged by the printout of the membership poll on medical issues. Some questions seemed a bit slanted in wording, but the important thing is that the AMA is genuinely trying to find out what its membership believes. It hasn't got to instant across-the-nation electronic voting and tabulation yet, but it's on the way.

So off goes my check for \$110. I write it with open eyes. I think the AMA is going to change very slowly, but I'd like to help in some of that changing. So far as the future of medicine is concerned, the AMA is really the only game in town.

Dr Halberstam's article originally appeared in the Nov 20, 1972 issue of MEDICAL ECONOMICS, and is reproduced here through the courtesy of that publication. Reprints of the article are available at nominal cost. Write: Membership Committee, AMA, 535 N Dearborn St, Chicago Ill 60610.

EDITORIAL

Keeping the Patient Away

With the recent talk about increasing federal involvement in health care, we might want to ponder the lessons of a strike by Israeli doctors against their official medical system.

In the course of the recent strike, doctors refused to treat patients through Kupat Holim, the Israeli equivalent of a national health plan which charges no fees for almost all its services. Instead the doctors worked through their private practices, in which they do charge fees.

According to official sources, 88% fewer patients have been going to doctors. And deaths have declined by 20%.

The last figure admittedly reflects the great decline in nonemergency operations during the strike. But the overall figures show that completely free access to doctors may not be identical with high-quality medical service. According to the director of Kupat Holim, Asher Yadlin, patients "merely went because it was free. For some, particularly older women, a visit to the clinic has been the social high point of the day." Doctors admit they could hardly do a decent job with so much traffic. "Our doctors see up to 80 or 100 patients a day," said one. "They can barely say hello in that time, much less carry out a serious examination."

When you stop to think about this kind of health care, perhaps it's not so surprising that the Israeli death rate dropped when the strike closed down the national service. Spared the rush of patients with minor complaints, doctors could do a better job of treating serious illnesses. Or to put it more or less in an economist's language, the national health plan did a lousy job of allocating scarce resources.

Mr Yadlin recognizes this problem, and has come up with a solution that may be a hint to proponents of nationalized health care elsewhere. He wants to introduce a schedule of fees.

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your medical faculty at work

by John Sargeant, Executive Director

The Council met on Saturday, Sept 15, 1973 and took the following actions:

1. Developed a list of nominees for submission to the House of Delegates for its consideration and election to the Board of Directors, Maryland Foundation for Health Care.
2. Adopted a recommendation of the Medical Economics Committee dealing with the Professional Liability Insurance program of the St Paul Companies in Maryland. They are as follows:
 - a) Dividing the state into three territories:
 - I — Montgomery and Prince George's Counties
 - II — Baltimore City, Baltimore County, Anne Arundel, and Howard Counties
 - III — Remainder of the State

- b) Increase in premium structure:

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1	\$ 239.00	430.00	382.00	311.00
2	419.00	754.00	670.00	545.00
3	907.00	1633.00	1451.00	1179.00
4	1210.00	2178.00	1936.00	1573.00
5	1512.00	2722.00	2419.00	1966.00

3. Approved formation of its own Insurance Agency for the provision of professional liability insurance to its members and other physicians.
4. Received the Annual Report of the Professional Liability Cases, closed or otherwise disposed of, as prepared by the Commission on Medical Discipline.
5. Adopted the following motion in connection with activities of the Health Services Cost Review Commission:

Resolved, That the Council Chairman appoint an ad hoc committee to analyze and release any data it can obtain regarding incomes of hospital-based physicians; and

Resolved, That this committee contact the various specialty societies involved for the purpose of assistance in obtaining such data prior to any face-to-face meeting with representatives of the HSCRC; and

Resolved, That this group also meet with representatives of the Maryland Hospital Association for the purpose of ascertaining what joint action, if any, can be taken with respect to what could or should be a reasonable contract for physicians to enter into with hospitals; and

Resolved, That any other action deemed appropriate be taken in an attempt to resolve this problem.
6. Referred a request from the Maryland—DC Society of Anesthesiologists that the Faculty employ a "Legislative Watchdog" to the Legislative Committee Chairman.
7. Empowered the President to direct a letter to the Governor regarding what appears to be bias on the part of HSCRC Commission members and staff.
8. Set Council meeting dates for 1974.
9. Adopted the following recommendation of the Executive Committee:

The Faculty strongly opposes the Regional Planning Council collection of physician data currently underway and which has been solicited from hospitals as follows:

"A listing of physicians who have admitting privileges at each institution, their specialty, their office location, and the number of patients admitted to each institution by each physician. This information would be used to determine the effect of physician referral patterns on utilization and to develop physician productivity profiles."

10. Referred proposed changes in the list of Reportable Diseases to the Motor Vehicle administration to an ad hoc group formed to study this particular legislation and the list of such diseases.
11. Authorized the Executive Director to direct a further communication to the Regional Office, HEW, in Philadelphia Pa, regarding PSRO areas. This communication will emphasize the designation of areas as defined by the Faculty and as components and its member physicians wish such designation, rather than accepting suggested designations by Comprehensive Health Planning.

The House of Delegates met in Semiannual Session on Saturday, Sept 15, 1973 and took the following actions:

1. Approved Emeritus Membership for Leonard Hays MD, Barnesville Md, on recommendation of the Council and Prince George's County Medical Society.
2. Endorsed the AMA Medcredit proposal as introduced in the US Congress and cosponsored by more than 180 members.
3. Amended the Bylaws by deleting the Committee on Contractual Arrangements and the Committee on Medical Emergency Disaster Services; and amended the section dealing with Peer Review by adding:
 "provided, however, that if a peer review committee of a component society fails to initiate or pursue action with respect to any complaint of an aggrieved party within 90 days of referral of matter to it, the Peer Review Committee may take original jurisdiction of the matter."
4. Requested the Bylaws Committee to draft an amendment that would require at least one sponsor of resolutions being considered to appear before the Reference Committee at its hearing; or such resolution will not be considered by the House or Reference Committee.
5. Approved the auditor's statement for 1972, as presented by the Treasurer.
6. Received various committee reports for the 1972-1973 year, all having been published in the August 1973 *Maryland State Medical Journal*.
7. Adopted the following motion:
 To amend the resolution adopted by the House of Delegates on Sept 11, 1971 relating to the establishment of a Maryland Foundation for Health Care by substituting for it the following:
Resolved, That the House of Delegates approves the continued existence of the Maryland Foundation for Health Care as established under the authorization of a resolution of the House of Delegates adopted Sept 11, 1971 and approves in principle the provisions of the current Bylaws of the Maryland Foundation for Health Care provided that 1) Said Foundation shall be a functioning body of the Medical and Chirurgical Faculty of Maryland; 2) That all amendments to the current Bylaws of the Foundation be approved by the Council of the Faculty; and 3) That the Executive Director of the Faculty be the Chief Executive Officer of the Foundation.
8. Adopted the following substitute motion of the Reference Committee:
Resolved, That while it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve the high quality of patient care in Maryland, the Medical and Chirurgical Faculty of the State of Maryland opposes any regulation that would interfere in the provision of high quality medical care; and that would tend to increase federal control over the practice of medicine; and be it further
Resolved, That the Council of the Medical and Chirurgical Faculty of the State of Maryland work actively to seek the repeal or modification of either the PSRO law or regulations relating thereto should events occur that could lead to federal control of the practice of medicine.
9. Adopted the following recommendations of the Ad Hoc Building Committee:
 1. *Resolved*, That the Ad Hoc Building Committee is hereby authorized to negotiate the purchase of property located to the south of the present Faculty building and adjoining it, at a sum that is prudent, and that would provide for early possession. It is estimated this would be approximately \$85,000, based on previous sales in the general area. It is understood that in so negotiating, the purchase will be on the basis that the land will be cleared and present buildings razed.

2. *Resolved*, That the Ad Hoc Building Committee be authorized to have architects prepare plans for a new office building to adjoin the present Faculty building with the costs to come from the present building funds.
3. *Resolved*, That the Ad Hoc Building Committee present to this House of Delegates the cost of such an addition, together with the mechanisms to be used for its financing; this report to be made at the 1974 Annual Meeting.
10. Adopted the following motion of commendation of John M Dennis MD:

WHEREAS, John M Dennis MD, Chairman of the Department of Radiology at the University of Maryland School of Medicine, has for many years been an active and valued participant in the affairs of the Medical and Chirurgical Faculty of the State of Maryland; and

WHEREAS, He has served with distinction as the first and only Chairman of the Commission on Medical Discipline, combining leadership to the members of the Commission with tolerance and understanding toward those persons coming before it; and

WHEREAS, Dr Dennis has been appointed Acting Dean of the University of Maryland School of Medicine, necessitating his relinquishing his chairmanship of the Commission; now be it

Resolved, That this House commends Dr Dennis for his distinguished contribution to Medical and Chirurgical Faculty affairs and to the Commission on Medical Discipline, and expresses its pleasure at his appointment as Acting Dean of the University of Maryland School of Medicine; and be it further

Resolved, That the Secretary be instructed to spread this resolution upon the minutes of this meeting, and a copy be sent to him.
11. Adopted the following motion offered by Prince George's County Medical Society:

WHEREAS, The Senate Finance Committee has very recently reported out a bill favorably, S1179, that reforms the provisions for private pension plans; and

WHEREAS, This bill provides for a limitation on contributions to a retirement system of an owner-employee of a professional corporation to a maximum of \$7,500 or 15% of his income, whichever is less; and

WHEREAS, No such limitation is placed on owner-employees of large corporations; now, therefore, be it

Resolved, That this House of Delegates expresses itself as being in opposition to the discriminatory provision of the bill in respect to its limitations on contributions by owner-employees of small businesses and professional corporations; and that immediate contact be made with Maryland's Congressional Delegation as well as all members of the House Ways and Means Committee expressing its opposition to such discriminatory provisions.
12. Received the results of the election of members of the Board of Directors, Maryland Foundation for Health Care, which were as follows:

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Katherine H Borkovich	Internist	City
Douglas G Carroll	Internist	City
Marco Clayton	ENT	Harford Co
John M Dennis	Radiology	City
Russell S Fisher	Forensic Path	City
Edward J Kowalewski	Family Practice	City
Paul A Mullan	Pediatrician	City
Eugenia E Phillips	Ob-Gyn	City
Eugene Riley	General Surgeon	Balto Co
Donald Roop	Public Health	Balto Co
Alan C Woods	Surgeon	City
<i>Eastern District</i>		
Robert W Farr	Family Practice	Kent Co
Philip Insley Jr	General Surgeon	Wicomico Co

South Central District (3 Montgomery Co; 2 Prince George's Co)

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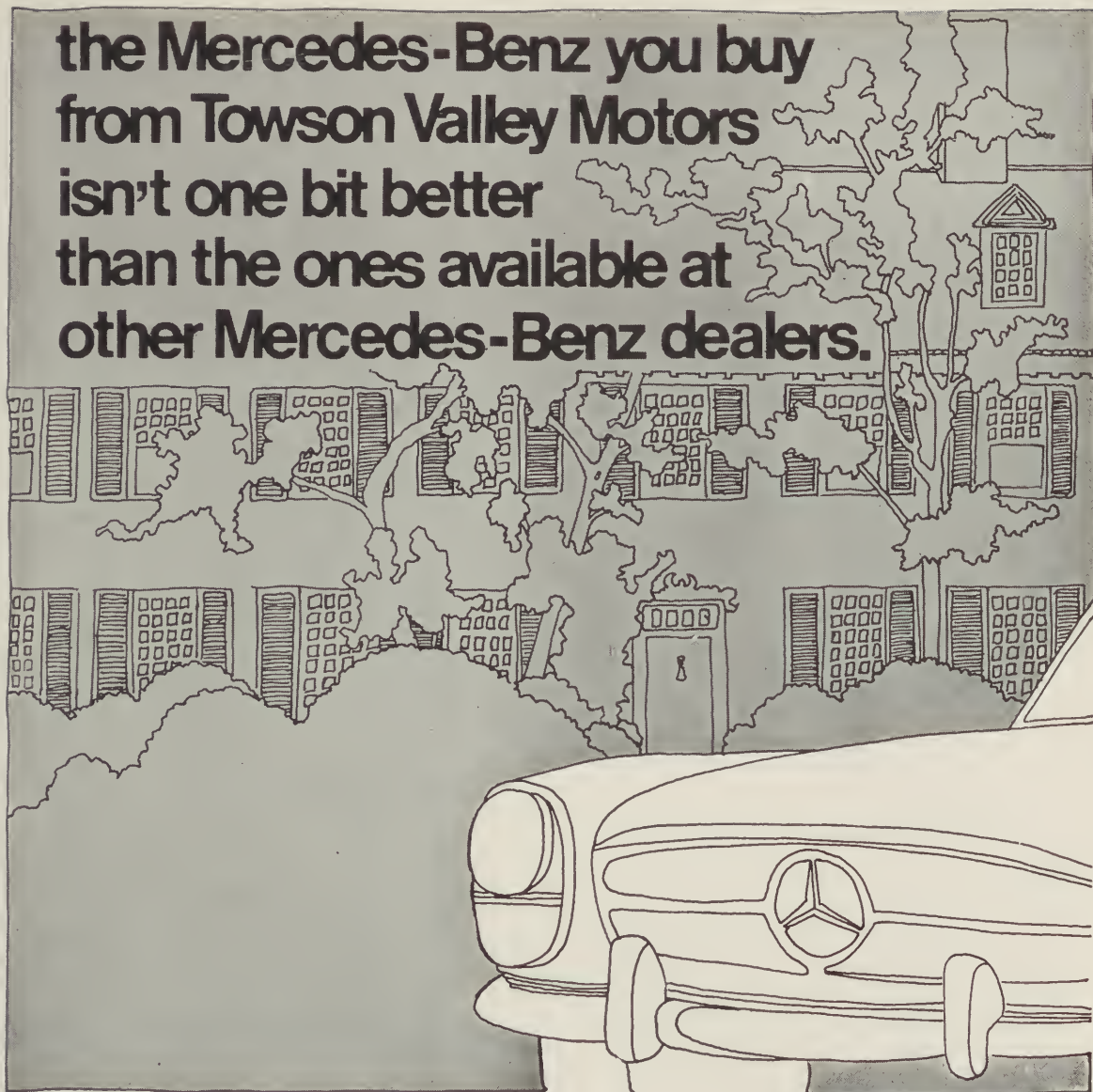
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age require that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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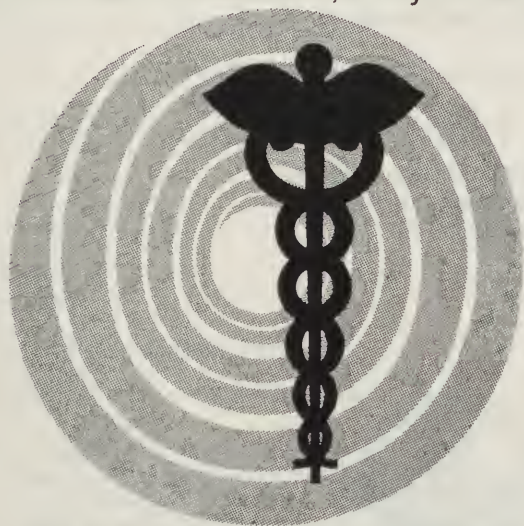
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- Jan **Family & Systems Theory & Family Psychotherapy**, postgrad crs for nonpsychiatrist physicians, Washington. Meets quarterly in 3-day sessions. Contact: Dr Murray Bowen, Dept of Psychiatry, Georgetown Univ Med Cen, Washington DC 20007

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- Feb 6-June 12 **Internal Medicine in Review**, 5:30-7:30 PM, 19 Wednesdays, \$50, Prog Chmn: DT Lewers MD
- Jan 31 **Problem-Oriented Record, Medical Audit & Utilization Review**, \$100, Prog Chmn: Drs Kushner, Rapoport & Wentz
- & Feb 1
- Feb 14 **Psychiatric Problems in Med Practice, Pt II**, \$35, Prog Chmn: VaHuffer MD
- Feb 28 **Recent Advances in Obstetrics**, \$35, Prog Chmn: EB Middleton MD
- Mar 7 **Dermatology Day**, \$35, Prog Chmn: HM Robinson MD
- Mar 13-15 **Problems & Process in Internal Medicine, Advances in Internal Medicine Considered in Problem-Oriented Manner**, \$150 (Residents \$90), Prog Chmn: Drs Staniford, Rapoport & Kushner
- Mar 24-26 **Advances in Practical Neurology**, \$125, Prog Chmn: Drs Nelson & Price
- Mar 28 **Psychological Management of Handicapped Child**, \$35, Prog Chmn: Drs Cornblath & Seabold
- Apr 11 **Emergency Medicine—Role of Shock Trauma Unit**, \$35, Prog Chmn: Wm Gill MB
- May 16-17 **Clinical Review of Transfusion Therapy & Blood Clotting Disorders**, \$100 (Residents \$75), Prog Chmn: RB Dawson MD
- Jun 6 **Symposium on Pediatric Neoplasia**, \$50, Prog Chmn: MJ Wizenberg MD

AMERICAN COLLEGE OF PHYSICIANS

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- Jan 7-11 **Workshops in Physiology, Diagnosis & Treatment of Electrolyte & Acid Base Disorders**, Univ of Penna Sch of Med, Philadelphia
- Jan 9-12 **Chemotherapy of Infectious Diseases: New Developments**, Univ of California, San Diego
- Jan 21-23 **Clinical Application of Recent Advances in Medicine**, Oschner Med Clinic, New Orleans
- Jan 21-25 **Hematology—1974**, Univ of Miami Sch of Med, Miami

MISCELLANEOUS MEETINGS

- Jan 14-19 **#Miami Winter Symposia (Biochemistry)**, Sheraton Four Ambassadors Hotel, Miami
- Jan 16-19 **#8th Anl Postgrad Seminar in Surgery**, Eden Roc Hotel, Miami Beach
- Jan 23-27 **#Pediatric & Adult Urology**, Playboy Plaza Hotel, Miami Beach
- Jan 28-31 **#Modern Approach to Neurological Medicine**, Sheraton Four Ambassadors Hotel, Miami
- # Contact: Div of Cont Med Educ, Univ of Miami Sch of Med, P O Box 875, Biscayne Annex, Miami Fla 33152
- Jan 30-Feb 1 **Advances in Angiography Technical, Equip, Clinical - Phase II**, Sands Hotel, Las Vegas. Sponsors: Dept of Radiology of Shadyside Hosp & Univ of Pittsburgh Sch of Med. Contact: Shadyside Hosp, Radiology Seminar, Dept of Radiology, 5230 Centre Ave, Pittsburgh Pa 15232
- Feb 1-2 **Intro to Neuroradiology**, Oklahoma City. Contact: Off on Cont Med Educ for Physicians, Univ of Oklahoma Col of Med, PO Box 26901, Oklahoma City Okla 73190

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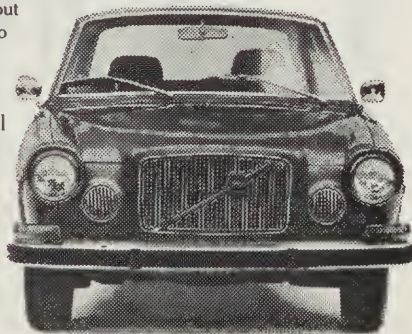
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

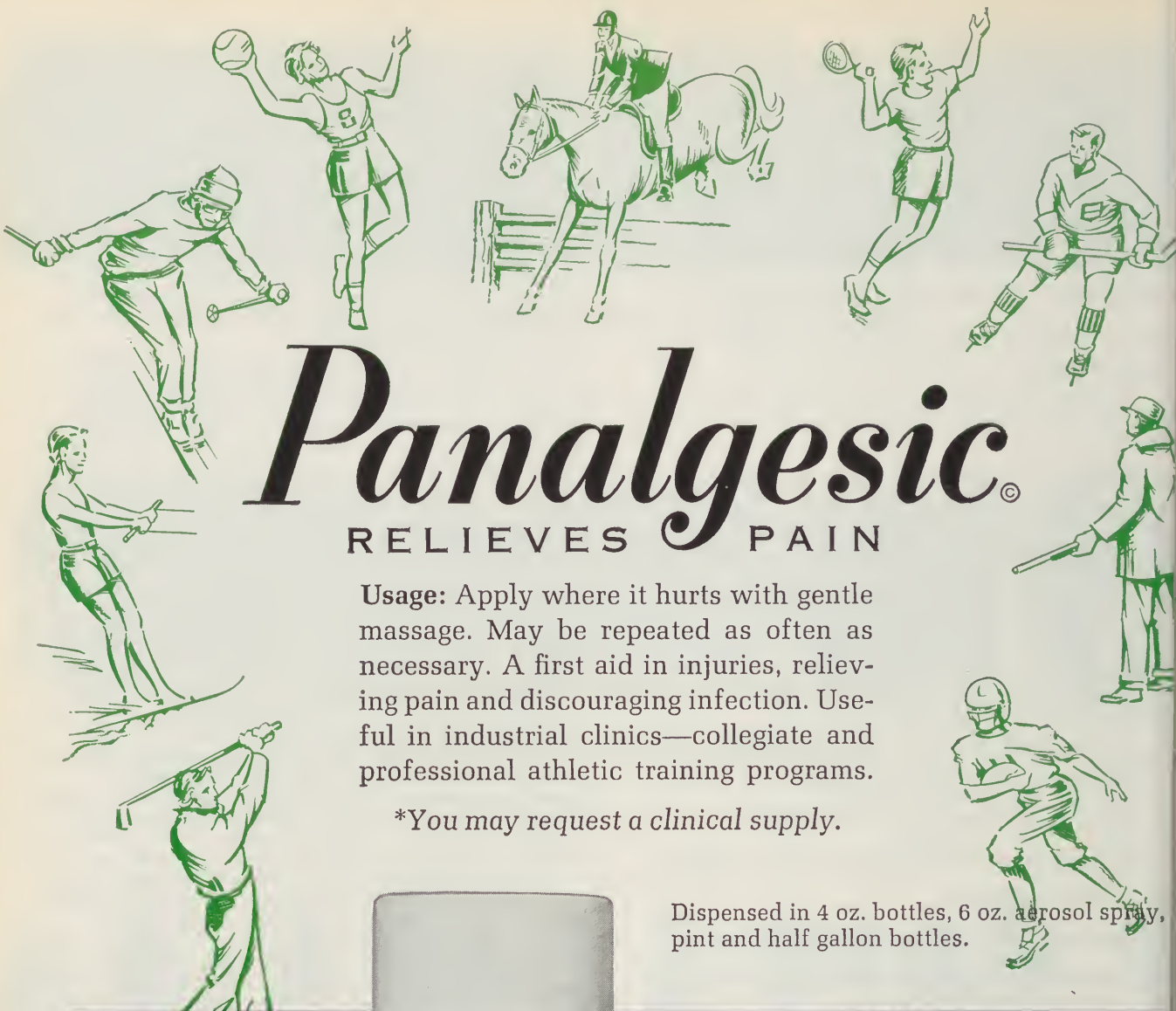
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THE UNION MEMORIAL HOSPITAL

The Union Memorial Hospital was incorporated in 1854; it was known as the Union Protestant Infirmary until 1920. On Jan 5, 1855, the hospital opened in a small house, formerly a private residence, at the corner of Baltimore and Stricker streets. It was the first Protestant hospital in Baltimore, owing its existence to a few ladies who were members of the Protestant Episcopal Church.

A lot on Division Street near Mosher was soon purchased by the hospital. Ground was broken and the cornerstone was laid with appropriate ceremonies in 1857. A Bible and a copy of the Constitution and Bylaws of the Infirmary were placed in the cornerstone.

Union Memorial Hospital has always had a close relationship with the Johns Hopkins Hospital. It is interesting to note that the name of Johns Hopkins is found among the first Union Memorial trustees. He served on the Board from 1855 until his death in 1873, and gave much of his valuable time to the institution.

The Infirmary's name was changed officially by an Act of the Maryland Legislature in 1920 from "The Union Protestant Infirmary of the City of Baltimore, Incorporated 1854," to "The Union Memorial Hospital, Maryland, Incorporated 1854"; the seal of the hospital was changed accordingly.

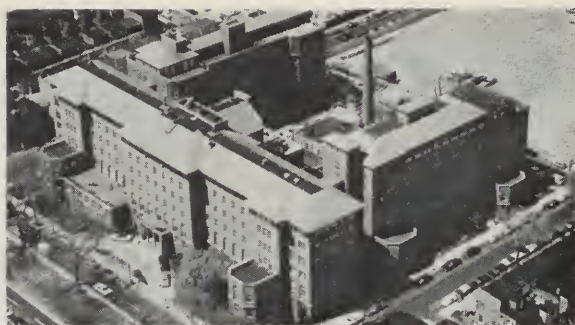
The Union Memorial Hospital School of Nursing was organized in 1890.

Ground was broken for a new hospital in 1922. A handsome fireproof brick structure with six stories, an attic, basement, and power plant was ready for occupancy on Calvert and 33rd streets in 1923; it had a capacity of 149 beds.

Plans were drawn at the same time for a new wing, the Bauernschmidt Memorial, carrying out the architecture of the main building, and the imposing Johnston Wing, with an open roof for sun treatment.

Current and Planned Additions

Ground was broken on Sept 14, 1972 for yet another new Union Memorial Hospital. It is expected that the complex, being constructed at a cost of some \$30 million, will be ready for occupancy in early 1975. It is being built one block north of the existing hospital, on a 2.3-acre plot. The entrance will face north toward University Parkway. The new building will be



Bird's-eye view of current Union Memorial Hospital buildings



Recently opened parking plaza by night



Proposed office building for doctors

bounded on the west by Calvert St, on the south by 34th St, and on the east by Guilford Ave. An 11-floor concrete, brick, and steel structure, the new 393-sq-ft facility will house 379 acute and intensive care beds, as well as the major portion of the hospital's ancillary and support services.

Construction management, a new concept in the construction of hospitals, is being used in this project. Project control is placed in the hands of a firm that has experience in building and design and also in engineering, cost control, and purchasing. The construction management firm, Knott Industries, guarantees compliance with architectural plans and completion within the budget, and pledges to insure on-time completion.

The new hospital (pictured on the cover) will almost entirely replace the existing hospital,

which will continue to house administrative offices, laboratories, two nursing schools, a 51-bed pediatric unit, and other supportive services.

The total bed complement projected for the entire complex is 430, including the 51 pediatric beds in the existing hospital.

The Emergency Care Center, with 17,200 sq ft of floor space, will double the size of the present emergency department. To establish rapid transit from the Emergency Room, the Intensive Care Unit, and Delivery Rooms, the Operating Suite will be located on the ground floor. All mechanical equipment will be housed on the second floor. Rooms for patients will occupy the fifth to ninth floors. Nine elevators will be provided for patients, visitors, supplies, and hospital personnel. A five-story parking plaza, already in use, complements the new hospital structure. This 540-space facility replaces UMH's former 114-space parking lot. A doctor's office building, to be located at 3300 N Calvert St, is presently in the planning stage.

George H Yeager MD, is President and chief administrative officer of the hospital; Robert E Martin MD, is Chief of Staff; and Mrs Frances D Tompkins RN, is Director of Nursing.

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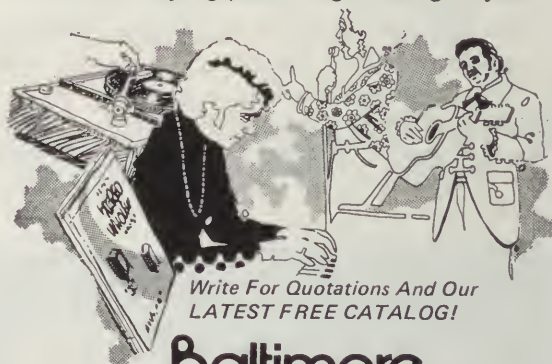
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MEET YOUR NEW COUNCIL MEMBERS

Elected at the 1973 Annual Meeting, Roland T Smoot MD assumes the office of Councilor for the Central District at the conclusion of the 1974 Annual Meeting.

Dr Smoot was born in Washington DC Feb 12, 1927. He received his BS from Howard University in 1948 and his MD there in 1952.

His internship and first year of residency was taken at the K B Reynolds Memorial Hospital in Winston-Salem NC.

His second and third years of residency in Internal Medicine at the VA Hospital in Tuskegee Ala brought him to 1956 when he joined the medical staff at the VA Hospital, Tuskegee Ala.

He came to Baltimore in 1960 to enter the practice of Internal Medicine and has offices in the Garwyn Medical Center on Garrison Blvd.

Dr Smoot has been a member of the medical staff at Provident Hospital since 1960 and served as Chief of Medical Service there from 1962 to mid-1972.

He is also currently a mem-



Dr Smoot

ber of the medical staffs at St Agnes, University of Maryland, and the Johns Hopkins hospitals.

Since 1966, he has served as part-time Instructor in Medicine at the Johns Hopkins School of Medicine. He has also served as part-time Clinical Assistant Professor of Medicine at the University of Maryland School of Medicine.

Dr Smoot was recently elected President of the Maryland Thoracic Society, the society of physicians concerned with lung diseases. He served as Vice President in 1971-1972, and as President-elect in 1972-1973.

The Maryland Blue Shield

numbers him among its Board of Directors. He is also a member of the Board of Directors of the Baltimore City Medical Society.

In 1965 he became a Fellow of the American College of Chest Physicians, and in 1970 a Fellow in the American College of Physicians.

In addition to AMA and Med-Chi memberships, he is an Associate in the American College of Physicians, a member of the American Thoracic Society, and of the National Medical Association.

Following an interest in a major health problem in Baltimore, Dr Smoot served as Chairman of the Baltimore City TB Committee of the American Lung Association of Maryland from 1969 to 1972.

He, his wife, and four sons reside at 3817 Copley Road in Baltimore. The sons, ranging in age from 17 to 8, attend Gilman School in Baltimore.

His wife, Minnie, is active in PTA work and, until recently, served on the Board of Directors of Florence Crittenden Services of Baltimore Inc.

Bowling and bridge are Dr Smoot's chief recreational and spare-time hobbies.

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Doctors in the News



RADIOLOGIC TECHNOLOGISTS—Four students graduated recently from the Mercy Hospital (Baltimore) program in radiologic technology. Diplomas were presented by Franklin Angell MD, the hospital's Chief of Radiology, pictured with the graduates. Dr Angell directs the two-year course; graduates are eligible for national registry examinations. Four students are now in their second year; nine enrolled this fall.

The Maryland Chapter, Health Officer, Baltimore County Department of Health, has announced the election of the following officers, all MDs:

Gaylord S Knox, Baltimore, President; Robert L Hirschfeld, Baltimore, President-elect; David O'Brien, Annapolis, Secretary; and Max Lai, Havre de Grace, Treasurer.

Shahid Aziz MD, Catonsville, has been appointed Assistant Chairman of the Department of Pediatrics at St Agnes Hospital in Baltimore. He becomes their first full-time assistant chairman.

Merton L White MD has been elected Chairman of the Montgomery County Chapter of the American National Red Cross. He is a past president of the Montgomery County Medical Society.

Donald J Roop MD, County of Neurology, School of Medi-

cine, University of Maryland at Baltimore, has received the Senior Fellowship Award for the Purpose of Research and Teaching from the Alexander von Humboldt Foundation of the Federal Republic of Germany.

The award was made under the "Special Program for the Facilitation of Specialty Related Cooperative Work between Research Institutes in the Federal Republic of Germany and the United States of America," initiated by the West German government in 1972 to commemorate the 25th anniversary of the Marshall Plan.

Dr Heck has been invited to serve as Visiting Professor in the Department of Neurosurgery at the Medizinische Hochschule in Hanover, West Germany, where he will pursue his work on new patient-monitoring techniques, brain circulation, and intracranial pressure.

A native Baltimorean, Dr Heck received his bachelor's degree from Hopkins in 1954 and his MD from the University of Maryland School of Medicine in 1958.

Two Maryland doctors have been designated as Fellows of the American College of Cardiology, according to J O'Neal Humphries MD, Baltimore, ACC Governor for Maryland. They are:

John H Hornbaker Jr MD, Hagerstown, and Frank J Talbot MD, Marlow Heights.

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woman's auxiliary



MEDICINE'S ROLE IN THE BICENTENNIAL CELEBRATION

1973 is almost behind us. In two short years, our country will be celebrating the 200th anniversary of its independence. Communities throughout the 50 states will celebrate this memorable event in imaginative ways. Maryland, one of the original 13 states, will be commemorating with historic events throughout the state. Will the history of medicine in Maryland be part of the story? Not unless we develop the materials necessary to tell the story.

Medicine played an important part in the early struggle during the war years and following the Revolution with the settling of the frontier areas. Maryland's growth in medical facilities and the recognition of its outstanding physicians should not go unrecognized. Who will tell the story?

How to Get Started

Retired physicians are probably the best place to begin the necessary research. Interviews by Auxiliary members taped and then transcribed can provide a permanent record of recollections.

Older Auxiliary members especially should find a challenge in a project of this type since it could be developed over a period of two years and could be done individually as time permits.

Public records in libraries, county historical societies, and county medical societies are other valuable resources. After all possible sources have been checked and compiled, plans can be developed for exhibits, skits, and publications which will tell the story to the public.

The Southern Medical Auxiliary began a project in 1930 called "Research and Romance of Medicine." They have compiled a collection of material pertaining to outstanding contributions to medicine by southern physicians both as individuals and as groups. All state auxiliaries, county auxiliaries of the southern states, individual members of these groups, physicians, and serious students of medical history may obtain material from their files, or may contribute to the file. They accept medical histories, biographies of doctors or outstanding health per-

sonnel, histories of hospitals or other health facilities, histories of county or state medical societies and/or their auxiliaries, histories of epidemic disease, medical discoveries, etc.

Plan Now

If every county auxiliary prepared to tell its county history of medicine in 1976, the State Auxiliary and Med-Chi Faculty could have a fine exhibit worthy of general public interest. Time is growing short and we must begin now if we are to be ready for '76. The county medical societies should encourage their auxiliaries to undertake a project relevant to their county's medical history. The only limiting factor is your collective imaginations.

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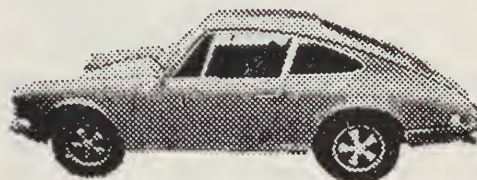
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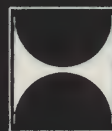
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executive director's newsletter

December 1973

DIAGNOSTIC WORK

Many physicians have inquired as to the name of a laboratory that will do diagnostic interpretations of the blood to ascertain if lead or mercury has contaminated it. The Maryland State Dental Association is urging all dentists to ask for this type of test when they have annual physicals.

This type of test is not performed by many laboratories. Physicians Service Laboratory, Towson Md, does perform this test. Any person may be referred to this organization for drawing of blood for these tests.

JCAH RESPONDS

The Joint Commission on Accreditation of Hospitals has clarified somewhat its ruling regarding hospital privileges. In a recent bulletin it states:

"The Board of Commissioners added that, 'it is not necessary that each hospital use a complicated list of procedures and operations for delineation of clinical privileges in order to demonstrate compliance with present JCAH standards.'"

Hopefully, this will put this problem to rest once and for all.

WITHHOLDING TRANSFER OF PATIENT RECORDS

The Physician/Patient Relations Committee has ruled recently that it is unethical for a physician to withhold transfer of patient records pending payment of outstanding accounts. It also determined that the transfer of patient records, upon properly being requested, should not be withheld for any purpose.

Physicians are reminded of this and the provision in the Statute dealing with disciplinary powers that reads: "...failure to furnish details of a patient's medical record to succeeding physicians or hospital upon proper request."

STANDARD CLAIM FORM

A standard form for claims reporting is now available from the AMA. The form is the result of two years of study and development by an AMA-sponsored work group, which included representatives from Medicare, Medicaid, CHAMPUS, the Medical Group Management Assn, the National Assn of Blue Shield Plans, the California Medical Assn, the Health Insurance Assn of America, and the

Society of Professional Business Consultants. The work group will be maintained to make any necessary modifications in the form. The form is available in three styles. The first, a single form consisting of one page (OP-407), costs \$18.50 for 1,000; \$78.00 for 5,000; and \$138.00 for 10,000. The second consists of two pages, an original and a carbon (OP-408), and costs \$28.00 for 1,000; \$112.00 for 5,000; and \$210.00 for 10,000. The third is continuous form for computer printers (OP-409). Its cost is \$28.00 for 1,000, \$112.00 for 5,000, and \$210.00 for 10,000. Postage and handling is included in all of the rates. To order the forms, enclose check with order, specify order number and write Order Dept, AMA, 535 N Dearborn, Chicago Ill 60610.

NEW
GUIDELINES
FOR
MDs

The Physician/Patient Relations Committee has developed revised guidelines for Advertising and Solicitation. Copies are available from the Faculty office.

An open meeting will be held on

Wednesday, Jan 16, 1974 at 8:00 PM

at the Faculty building to hear comments and suggestions in connection with these proposals. Comments may also be made in writing.

Following this public session, further revisions will be made and the proposals will then be submitted to the Faculty's Council for approval.

Adoption by the Commission on Medical Discipline and the Board of Medical Examiners is several months away, inasmuch as these groups must also examine and solicit comments before final action.

RESOLUTIONS
FOR
ANNUAL
MEETING

Resolutions for the Annual Meeting must be received in the Faculty office before Friday, Feb 22, 1974 in order to be considered by that House. This is in accordance with Faculty Bylaws, Article XI, Section 26.


Executive Director

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Medical Miscellany

Chronic Lymphocytic Leukemia

The cooperation of physicians is requested in the referral of patients with chronic lymphocytic leukemia for studies being conducted by the Immunology Branch of the National Cancer Institute.

NCI investigators are currently attempting to develop reagents with specificity for tumor antigens in chronic lymphocytic leukemia.

Physicians interested in having their patients considered for admission may obtain further information by writing or calling Dr Howard B Dickler, Immunology Branch, National Cancer Institute, National Institutes of Health, Clinical Center, Room 4B17, Bethesda Md, (301) 496-1376.

AMA Expense Booklets

A 20.4% increase in physicians' professional expenses and only a 5.2% increase in their net income between 1969 and 1970 are noted in the 1973 edition of the AMA's "Red Book," *Reference Data on the Profile of Medical Practice*.

Produced by the AMA's Center for Health Services Research and Development, the Red Book and its companion Blue Book, *Reference Data on Socio-economic Issues of Health*, provide statistics on the health care industry. For copies of the 1973 editions, \$1.35 each, \$2.50 per set, write Order Dept, AMA Headquarters, 535 N Dearborn St, Chicago Ill 60610.

New Medicolegal Society

Branching out into a national organization to be known as the American Society of Law & Medicine Inc, the former Massachusetts Society of Law & Medicine has extended its concept of acting as a catalyst to bring together for continuing educational purposes the disciplines of law, medicine, insurance, education, and judiciary in a common meeting place.

The Society has nationwide representation in its 500 members; a national campaign for expanded membership is underway.

For further information, write or call the national office at 454 Brookline Ave, Boston Mass 02215 (617) 734-8316.

Ovarian Carcinoma Study

The cooperation of physicians is requested in the referral of patients for a controlled clinical trial of the treatment of advanced ovarian carcinoma being conducted by the National Cancer Institute's Medicine Branch at the Clinical Center, NIH, Bethesda.

Previously untreated patients with serous or undifferentiated ovarian carcinomas of all stages, under age 65, are needed.

Physicians interested in having their patients considered may call Dr V T DeVita Jr (301) 496-2031 or write Admitting Office, National Cancer Institute, Clinical Center, Room 10N-119, Bethesda Md 20014.

Grant to Johns Hopkins

The Johns Hopkins University School of Health Services has received a \$43,875 grant from the Educational Foundation of America for student support, Dr Malcolm L Peterson, Dean of the School, has announced.

The grant will be used for financial aid to students attending the School of Health Services which educates new types of health workers. The first class of students for the health associate program entered in September and the first class of nurse practitioners is expected next fall.

Work Experience Program

The Mental Health Association of Metropolitan Baltimore Inc has sponsored a Work Experience Program since 1955.

Dr Huell E Connor Jr, Psychiatric Consultant, has asked that we take this means of calling your attention to the potential of this Program.

The Work Experience Program is a rehabilitation program designed for individuals unemployed due to mental illness.

The Program provides personal and work adjustment training, thus enabling recovering psychiatric patients to become resocialized and readjusted to a work environment.

Under the direction of Mrs Lynn Caplan, Program Director, each trainee is evaluated regarding employability.

Dr Connor, as Psychiatric Consultant to the Work Experience Program, believes this Program, although relatively unknown, can be a valuable resource for the Psychiatric Community.

For further information, contact Mrs Lynn Caplan, Mental Health Assoc of Metro Baltimore Inc, 323 E 25th St, Baltimore Md 21218, (301) 235-9786.

Nursing Program Director

Dr Ellen T Fahy has been appointed director of the nursing education program at Johns Hopkins University School of Health Services. The appointment becomes effective July 1974. Dr Fahy is currently Dean and Professor of the School of Nursing, State University of New York at Stony Brook.

Dr Malcolm Peterson, Dean of the School, reports: "Dr Fahy intends to educate health practitioners who can provide primary patient care in the new health systems emerging in the nation today. During the coming months, she will work with our nursing faculty to develop the Nurse Practitioner Program for admission of students in the 1974 fall term. She also plans to work closely with Dr Marian Murphy, Dean of the School of Nursing at the University of Maryland, for a collaborative nursing education program."

The School of Health Services will offer a bachelor's degree program for nurse practitioners, supplanting the Johns Hopkins Hospital nursing school which closed last May.

Physician Placement Service

A 9% increase in the number of physicians registered with AMA's Physician Placement Service was noted in its 1972 statistical report. Some 4,534 physicians sought locations. The PPS also processed 3,174 applications offering practice opportunities.

The report showed an imbalance in supply and demand in the specialty of general or family practice with 762 opportunities listed and only 303 physicians seeking placement. For copies, write Physician Placement Service, AMA, 535 N Dearborn St, Chicago Ill 60610.

New Family Doctors

According to a recent survey, Family Practice, a new medical specialty of less than five years standing, is beginning to show tangible results.

Family practice residency programs have graduated 413 family physicians, the American Academy of Family Physicians survey shows. Following behind are 1,771 family practice residents in US training programs, an increase of 756 over last year.

A recent meeting of the joint AMA-AAFP Residency Review Committee for Family Practice resulted in the approval of ten programs (none in Maryland), bringing the total to 173, an addition of 40 programs in the last year.

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Labor and Health Care

In most instances, the medical profession thinks of National Health Insurance solely in terms of legislation passed or not passed by the Congress. Legislative action is, of course, the most far-reaching and thorough factor influencing the practice of medicine. There are, however, other influences on health care delivery of which we are perhaps not as well aware.

For example, there is a recent trend in labor negotiations which spotlights health care as a particular target of organizing and negotiating. This trend will likely increase, because health is a political issue which labor finds particularly effective.

Many labor unions are impressed with the health insurance clause won by the United Auto Workers in their recent contract with the Chrysler Corporation. In their own negotiations, other unions will use this health clause as a guide for their future demands.

The clause requires Chrysler to pay the full cost to its workers of any taxes levied to cover the cost of a national health insurance program. The proposed Kennedy-Griffiths Health Security Act includes a tax of 3.5% of the total payroll on employers and a 1% tax on employees. Under the United Auto Workers contract, Chrysler would not only have to pay the employer's share of the tax, but that of the employees as well.

For the medical profession, such an arrangement is surely thought-provoking. Medical care of patients who have absolutely no involvement in paying for such service would certainly be different from anything to which the profession is accustomed.

The economic implications of these contracts are certainly startling. Even the managed form of free enterprise under which this country now operates would certainly be drastically changed.

Various other unions have already put similar proposals into effect. Railroad companies have agreed to pay all of a payroll tax which finances the workers' retirement program. Employers of Amalgamated Clothing Workers Union members

now pay the full amount of health insurance costs and would be expected to pay the cost of any national health insurance program in full. Similar arrangements prevail in the contracts of steelworkers with the automobile and aluminum industries.

It is interesting to note a recent statement by Mr Max Fine of the Committee for National Health Insurance regarding the UAW-Chrysler pact: "The employer has recognized that the cost of business includes full health benefits whether public or private."

It is also interesting to note that a provision of the proposed Kennedy-Griffiths bill would prevent companies from paying a lower percentage of their payroll for a national health program than they now pay for private health plans. The difference would have to be used to provide additional benefits.

The Chamber of Commerce has estimated that the total cost of health insurance programs for nearly 120 million Americans is currently more than \$20 billion. Corporations have little or no control over health costs which are rising faster than the costs of any other benefits which they must provide their workers.

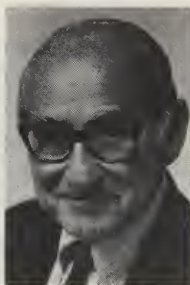
Should Federal standards be set for health insurance programs in the private sector as the method of health reform, clauses such as that in the UAW contract would not be applicable.

There are other industry-labor health trends which could affect the medical profession, particularly concerning matters of occupational health protection.

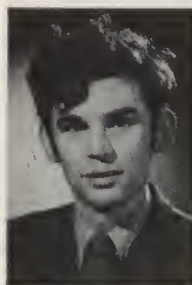
Furthermore, Senators Williams and Javits have introduced a bill (S.2008) which would establish a medical rehabilitation division in each state to supervise medical care and rehabilitation services for incapacitated workers. The legislation is formulated in such a way as to establish a peer review entirely outside the slowly developing PSRO standards. The bill has strong labor support.

We strongly urge you to become more familiar with labor agreements and legislation which will so vitally affect your profession.

AMONG THE SPEAKERS— 176th ANNUAL MEETING MEDICAL & CHIRURGICAL FACULTY BALTIMORE CIVIC CENTER APRIL 17, 18, 19, 1974



Dr S Friedman



Dr Sanders



Dr M Friedman

Among the many speakers scheduled for the 176th Annual Med-Chi Meeting at the Baltimore Civic Center, Wednesday, Thursday, and Friday, April 17-19, 1974, are Meyer Friedman MD, Stanford Friedman MD, and Roger C Sanders MD.

Meyer Friedman MD

The Role of Diet, Physical Activity, and Behavior Patterns in the Pathogenesis of Coronary Heart Disease will be the title of a talk by Meyer Friedman MD, Associate Chief of Medicine at the Mount Zion Hospital and Medical Center in San Francisco. This presentation will be co-sponsored by the Medical and Chirurgical Faculty and the Dairy Council of the Upper Chesapeake Bay Inc.

Dr Friedman received his AB from Yale University and his MD from the Johns Hopkins University School of Medicine. He served a general internship at the Kansas City General Hospital, a research fellowship in cardiology and a residency in cardiovascular research at the Michael Reese Hospital, and a residency in general medicine at the University of Wisconsin General Hospital. Since 1939, Dr Friedman has been Director of the Harold Brunn Institute for Cardiovascular Research; since 1948, he has been Associate Chief of Medicine—both at Mount Zion Hospital and Medical Center.

He holds membership in 14 societies including the American Medical Association, American Heart Association, American Society for Clinical Investigation, American Society for Study of Arteriosclerosis, and the Society for Experimental Biology and Medicine. Dr Friedman is certified by the American Board of Internal Medicine and the American Board of Cardiovascular Disease. His publications include three monographs on cardiovascular disease and over 400 articles dealing with cardiovascular research. This lecture is scheduled for Thursday, April 18, from 9:30 to 10:30 AM.

Roger C Sanders MD

Ultrasound will be the subject of a talk by Roger C Sanders MD on Thursday afternoon,

April 18. Dr Sanders is Assistant Professor of Radiology at the Johns Hopkins Medical Institutions. He received his medical training and underwent his radiology residency at Oxford, England. He is a Diplomate of the American Board of Radiology, a member of the Royal College of Physicians, and a Fellow of the Faculty of Radiologists of Great Britain. For the past three years, he has worked at Johns Hopkins and has taken a particular interest in ultrasound. Dr Sanders is the author of 25 papers, a number of them concerned with ultrasound with particular reference to its role in obstetrics, the kidney, and in the pediatric age group.

Stanford Friedman MD

Stanford B Friedman MD, Professor of Psychiatry and Human Development and Professor of Pediatrics at the University of Maryland School of Medicine, will speak on "Adult-Teenager Conflict: Problems of Communication" on Thursday afternoon, April 18. Dr Friedman was graduated from Antioch College in 1953 and the University of Rochester School of Medicine in 1957. He served an internship and residency in pediatrics at the Massachusetts General Hospital following which he served an assistant residency in psychiatry at the Adult Psychiatry Branch of the National Institute of Mental Health.

He was director of the Adolescent Clinic at the University of Rochester School of Medicine and Strong Memorial Hospital. After serving as assistant professor and associate professor of Pediatrics and Psychiatry at the University of Rochester School of Medicine and Strong Memorial Hospital, Dr Friedman was appointed professor of Pediatrics and Psychiatry at these institutions in 1972. He was a member of the Board of Directors of the Ordway School and is now an honorary member of the Board of Trustees of the school. Dr Friedman has received numerous awards and is a member of many societies including a membership on the Executive Council of the Society for Adolescent Medicine. He is the author of over 50 publications.

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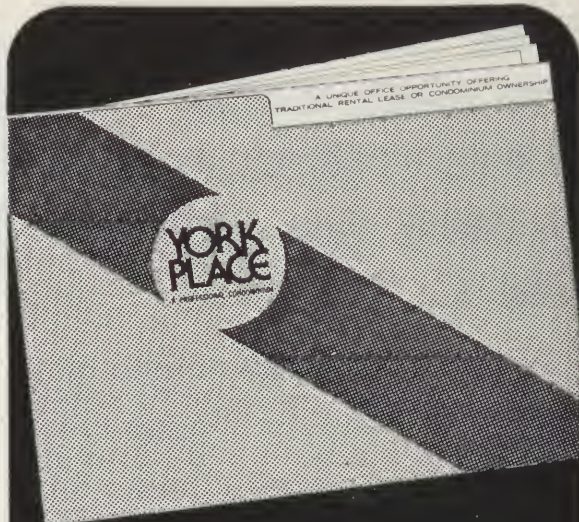
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ROBERT E FARBER MD MPH
Commissioner

Baltimore City health department

TB AND VD SUMMER SCREENING PROGRAM

In a preliminary report of the results of the 4th Annual Tuberculosis Screening Program, Dr Allan S Moodie, Director of the City Health Department's Bureau of Communicable Diseases, points out that Baltimore is taking large strides in reducing the incidence of two of its major diseases. This year's program, called "The Drive to Beat the Bugs," was carried on from June 4 to Aug 24 at 16 different locations in the city and for the first time screened for both syphilis and tuberculosis.

Altogether, 8,170 X-rays for tuberculosis were taken; 224 were considered suspicious and required further tests. No new cases of tuberculosis have been discovered although 37 cases are still being evaluated. Coupled with chemoprophylaxis and continuing treatment of known cases, the screening programs have helped Baltimore to attain a 90% reduction in childhood tuberculosis, and to attain a 40% reduction in new active adult cases over the last 12 months, a record unmatched by any other large city in the United States.

Syphilis was the second screening target. Some 3,591 blood tests for syphilis were made at the same 16 sites. Of the total tests, 273 were found positive and required further testing. While 38 suspects are still under medical evaluation, 23 previously undiagnosed new syphilis cases have been found and placed under treatment. The VD reactor rate of 7.3% for this screening program is extremely high. On the strength of this finding, the City Health Department's Division of Venereal Diseases is planning to open walk-in blood testing clinics in three health district buildings for year-round operation. This program will enable any resident of Baltimore City to obtain a free test for syphilis (STS) without delay and will greatly augment tests made routinely when patients come to City Health Department clinics for prenatal care, family planning,

or when they think they have the disease.

This year's campaign was assisted by the Baltimore City Branch Laboratory and a mobile X-ray van of the Maryland State Department of Health. Some personnel were supplied through funding by the US Public Health Service Center for Disease Control while others were employees of the Maryland State Department of Health, the Baltimore Urban Corps, the Baltimore Summer Corps, and the City Health Department. Posters and pamphlets were provided by the City Health Department and the American Lung Association of Maryland.

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NEIL SOLOMON MD PhD
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Maryland State department of health and mental hygiene

Maryland's New Regulation Governing the Admission of Involuntary Patients

IRENE L HITCHMAN MD

Dr Hitchman is Deputy Commissioner, Department of Health and Mental Hygiene, Mental Hygiene Administration, 301 W Preston St, Baltimore Md 21201.

If you have any questions concerning the implementation of this regulation, please forward them to Dr Hitchman. They will be answered in a subsequent issue of the Journal.

When the Mental Health Laws of Maryland were revised in 1970, special emphasis was given to the rights of the patients in mental hospitals. A provision was added making it mandatory to notify every patient of his admission status and advising him of his right to counsel with an attorney of his choice. Another provision was added mandating that all correspondence be forwarded to the addressee without being opened, that patients shall have access to telephones at all reasonable hours, that patients are entitled to receive visits from an attorney or clergyman of their choice, that no patient be deprived of his right to vote, receive, hold or dispose of property, unless he has been declared to be incompetent by a Court.

Section 12 of Article 59, dealing with the involuntary admission of patients on the application of a family member, accompanied by two physicians' certificates, was discussed extensively by the Commission charged with the revision of the Mental Health Laws at that time. After a great deal of consideration, it was decided to retain the provision without substantive change. Since then, however, the constitutionality of involuntary admissions without judicial hearing has been questioned in several states as well as in Maryland and a Class Action Suit was filed against the Secretary of Health and Mental Hygiene and the Commissioner of Mental Hygiene by lawyers associated with the Legal Aid Bureau. A bill was passed by the Legislature in

1971 providing a Mental Health Information and Review Service. This law has never been implemented because its constitutionality was questioned by the Judicial Branch of the Government.

Finally, with the cooperation of the Attorney General's Office, Regulation D (10.04.03) was developed which, in essence, mandates that any facility licensed by the Department may receive and take into an Observation Period Status any person upon application of a family member or friend and certification by two physicians in accordance with the provisions of Article 59, regarding involuntary admissions.

The patient assigned to the Observation Period Status shall receive care and treatment as required, provided that he shall not be required to take medication which will substantially adversely impair his ability to participate fully in his hearing.

A separate system of records shall be maintained by each facility for persons in an Observation Period Status. These records shall not be integrated with other patient records and shall not be disclosed to anyone except upon permission of said person or upon summons or subpoena.

During the time a person is in Observation Period Status, he shall have the right to consult with his family, legal counsel, medical practitioner, or certified clinical psychologist of his own choice and at his own expense. At the end of the first working day he shall be advised and notified, in writing, of the date, time, and place of a hearing to be held regarding his admission status. The notice shall set forth the name or names of the proponent of the person's admission (signer of the application) and again notifying him of

his right to consult with legal counsel, to be examined by and consult with a physician or certified clinical psychologist, the right to be represented by counsel and to call witnesses and to present evidence at the scheduled hearing. The notice shall also inform him that under appropriate circumstances a lawyer may be obtained through the Legal Aid Bureau, Lawyer Referral Service, and other agencies, if he does not have an attorney.

Every patient must be examined by a psychiatrist within 24 hours after his confinement in Observation Period Status.

Every patient involuntarily confined to a facility under the provision of Article 59, Section 12, shall have a hearing within five working days of the date of his confinement. Such hearing may not be waived by the patient unless he knowingly and personally makes the waiver in the presence of the Hearing Officer.

At the hearing, the person whose admission or retention as a patient is sought shall have the right to be represented by legal counsel of his choice, shall have the right to cross-examine adverse witnesses, shall have the right to present witnesses on his own behalf, and shall have the right to present other relevant evidence. Upon his written request, the patient may have an administrative hearing six months after admission, one year after admission, and annually thereafter.

A mechanical recording of the hearing shall be made but no transcription shall be made unless and until an appropriate appeal is taken.

In order to justify admission or retention of the patient it must be affirmatively shown at the hearing by clear and convincing evidence that each of the following elements exist:

- 1) that the person whose admission or retention is sought is suffering from a mental disorder; *and*
- 2) that the person whose admission or retention is sought is in need of institutional and inpatient care or treatment; *and*
- 3) that the person whose admission and retention is sought presents a danger to his own life or safety, or the life or safety of others.

If, upon all the evidence, the hearing officer finds that any one or more of the foregoing has not been proved, he shall so certify and the person whose admission or detention is sought shall be released from the facility. If the hearing officer finds from the evidence presented to him that all of the foregoing elements have been proved, he shall so certify and the person whose admis-

sion or retention is sought shall be admitted or retained as a patient in the facility.

The laws dealing with reimbursement or payment for patient care shall be fully operative with regard to persons in Observation Period Status. A person in Observation Period Status shall be deemed to be an admitted inpatient for medical insurance coverage.

Every patient retained after the hearing shall again be notified in writing at the time of his admission that he has the right to request his release and, if not released, the right to receive a Judicial Hearing on the cause and legality of his admission and continued detention in accordance with Sections 14 and 15 of Article 59 of the Maryland Code. The Department shall receive prompt notice of each request for release and shall be available to him. Each request for release shall be submitted in writing. The Commissioner of Mental Hygiene shall proceed in accordance with Sections 8g and 18a of Article 59 to obtain the release of any patient found to be held contrary to the law. Unless the patient is released or voluntarily withdraws, in writing, his request for release, in the presence of a staff physician, such request after seven days shall be treated as a demand for Judicial Hearing and the Medical Administrator of the facility in which the patient is detained shall forward such demand to the appropriate Court for a Judicial Hearing.

The hearings shall be held in an appropriate room provided for such purpose at the facility in which the person is in Observation Period Status.

The regulation applies to every patient whose admission is sought on an involuntary basis to any mental health facility licensed by or under the jurisdiction of the Department of Health and Mental Hygiene. The regulation does not apply to facilities for the care of mentally retarded patients.

The hearing officers will be assigned to the State regional mental hospitals and will also hold hearings in each private facility located in the area served by the State's regional hospital.

The significance of the new regulation for the practicing physician is to realize that the mental health facility has no right to admit involuntarily a patient whom he has certified as having a mental disorder unless the patient is considered in need of institutional and inpatient care and is clearly dangerous to himself or others. The criteria for involuntary admissions are sharply defined now and will have to be strictly adhered to by the admission staffs of all facilities.

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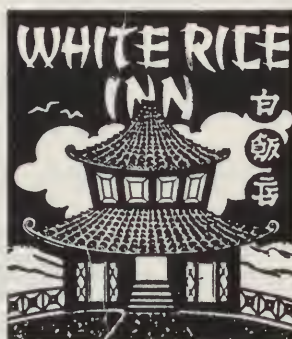
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Recommendations[†] on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

[†]For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combination products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



M-M-R^{*}

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M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT ¹
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

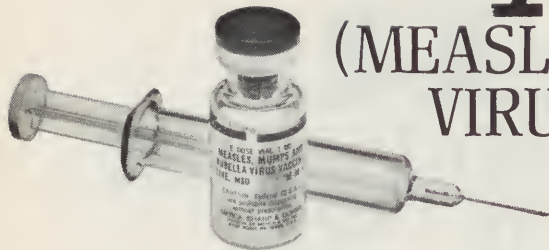
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

^{*}Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

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Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

Adverse Reactions: To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have

occurred very rarely with the individual vaccines may also occur with the combined vaccine. Experience from more than 44 million doses of all live measles vaccines given in the U.S. by mid-1971 indicates that significant central nervous system reactions such as encephalitis, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered. A survey conducted in New Jersey in 1965 showed that 2.8 cases of encephalitis (of unknown cause) occurred per million children, ages 1-9 years per 30-day period." However, the Center for Disease Control has analyzed the reported reactions following measles vaccines and pointed out that "the clustering of cases in the period 6 through 13 days after inoculation as well as the recovery of measles virus (probably the vaccine strain) from the CSF of one patient does suggest that some of these cases may have been caused by the vaccine." The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis with measles (one per thousand reported cases).

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID₅₀ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID₅₀ of mumps virus vaccine, live, and 1,000 TCID₅₀ of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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EXPERIENCES OF A SURGEON ON DIALYSIS

LOUIS J KOLODNER MD FACS

Dr Kolodner is a 61-year-old Baltimore surgeon who graduated from the University of Maryland School of Medicine in 1936. Currently, he is a senior attending surgeon at Sinai Hospital and an assistant professor of surgery at the Johns Hopkins University School of Medicine.

In this article, Dr Kolodner reveals his inner thoughts as a patient on dialysis while explaining the need for a Home Dialysis Organization.

(Since submitting this article, Dr Kolodner has returned to the operating room.)

Reprinted with permission from the University of Maryland Medical Alumni Bulletin, Summer 1973.

I am recording my thoughts as a surgeon who has end-stage renal disease so that others like myself—physician or lay person—who suffer renal failure will not despair (as I did originally) but look forward to dialysis and rehabilitation, as I feel I have been able to accomplish. The encouragement and care given by my beloved family, physicians, and friends played an important role in my recovery. No mundane tribute can convey my own thoughts of love for them.

Initially, I must state that my stays at the Johns Hopkins Hospital and Maryland General Hospital demonstrated to me the utmost skill in comprehensive medical care. It was a most pleasant revelation to see our two medical schools and affiliated community hospitals coming together in respect and cooperation initiated by the field of nephrology. The teamwork exemplified by the nephrologists, transplant surgeons, and other specialists is reflected in the excellent results achieved by dialysis and kidney transplantations in Maryland. A new type of mutual respect exists among men in this field and hopefully will set a trend for all other specialties.

Without the care afforded me by these great men and their teams I could not have survived or have been rehabilitated to my present degree of productivity.

Early in 1970, I began to note the onset of facial and peripheral edema. Consultation and a medical workup revealed evidence of a nephrotic syndrome, a rising BUN, proteinuria, and other chemical changes in my blood and urine. However, the cause of nephrosis could not yet be determined.

I had an impending sense that my future life would be restricted or perhaps that my demise was at hand and became increasingly engrossed in flashbacks of my prior years. My wife and I have always led a full and rewarding life. We

. . . God tempers the wind

traveled extensively abroad from 1958 through 1970 and have always enjoyed good food, art, music, books, and friends.

My early years were filled with memorable highlights. I spent seven years in surgical and pathological training which culminated in a surgical residency at Sinai Hospital in 1943. In 1944 through 1946, I served in the US Navy. During part of this time I was assigned to the USS Catocin (Admiral Hewitt's flagship) and sailed with this ship to the Yalta Conference where President Roosevelt and his party spent the night on board.

After my sea duty, I was appointed chief of surgery at the Naval Hospital in Palermo, Sicily. Returning from military service, I established an active surgical practice and gained my board certification. Later, I was appointed to the faculty of Johns Hopkins University Medical School.

My community and medical activities were numerous and I held surgical privileges in a number of hospitals in this city. I cite these to indicate the degree of activity prior to my illness.

After my initial symptoms, since I felt fairly well, I decided (against my doctor's advice) to take a tour around the world. My wife and I enjoyed a wonderful but rather exhausting trip. We were greeted in Hawaii, Japan, Thailand, India, Iran, and Israel by our friends, many of whom were former housestaff members that I helped train. While in Thailand, I presented a paper on the biliary tract at the Royal Thai Army Hospital. In effect, I quipped that I was saying goodbye to the world.

As the trip progressed, my illness progressed and its toll was apparent. I returned with much weight loss but continued to work. As my blood serum proteins fell lower and proteinuria worsened, I felt an indescribable feeling of weakness and asthenia. Multiple and repeated carbuncle infections of my extremities and trunk appeared and the edema increased.

Finally, I entered Georgetown University Hospital where a renal biopsy, urograms, numerous renal function and blood chemical tests revealed the severity of my disease and the poor prognosis that lay in store for me. It was if I had been given a calendar of duration of my remaining life.

It is amazing how one adjusts to the specter of impending morbidity. I found great solace in the writings of Stewart Alsop, who wrote after learning of his leukemia: "Something of the sort happens in combat. . . At first there is a naked sense of vulnerability, but then, God tempers the wind to the shorn lamb." A protective mechanism takes over and the intolerable becomes tolerable, the fear, less fearful, and death itself, "a necessary end that will come when it will come."

Alsop's reference to combat was very real to me. My D-Day experiences on Omaha Beach in the Normandy Invasion (LST 494) and the Invasion of Southern France (USS Lyon) became evermore etched in my memories. Those who have had combat experience will surely recall this sense of naked vulnerability and how one inevitably becomes enured to these feelings.

I continued to practice surgery, becoming increasingly more edematous and finding it difficult to function as the months progressed. I appeared to have had a remission in 1971 after a course of steroid therapy, but continued to get worse in 1972. However, I did take a trip to London and Italy in May of that year. I was active in London (with some difficulty) visiting Guy's Hospital and St George's Hospital to see the great Rodney Smith give operative clinics. I visited the Royal College of Surgeons and Hunterian Museum and was a guest at the Domus Medica of the Royal Medical Society in London. I was pleased and surprised to see the surgeons at Guy's Hospital using an electric scissors I devised and published in 1964.

In November 1972, I became acutely ill. I suffered with a sacral carbuncle, developed fever, and evidence of uremia appeared. At this point I resisted hospitalization for 48 hours, much to the chagrin of my family and physicians. I wanted time to decide whether to live or die. Any patient should have a right to make this decision if he has a clear sensorium and proper contact with his environment. The person's entire life is recalled in these hours of contemplation.

I felt if I had to be a burden to my family, or if recovery would be less than satisfactorily complete, I did not want to live. Indeed, I was not sure if I could be rehabilitated to live a satisfactory quality of life, bearing in mind my lifestyle prior to my illness.

After much urging by my wife, children, and doctors, I was admitted to Johns Hopkins Hospital. Then, the diagnosis of end stage renal disease, uremia, and staphylococcus septicemia was made. The septicemia accelerated the renal disease and produced profound changes in my

clinical condition.

Care by my own physicians and the housestaff was magnificent and superb beyond description. Herculean efforts by all my doctors, nurses, and paramedical teams helped assure my survival (prognosis was very poor on admission and was hampered by my sensitivity to penicillin).

Five physical examinations on the day of admission were exhausting but apparently necessary (by various physicians, housestaff members and a student). Try five (breathing deeply) physical examinations in good health and see how you weather it, let alone when you are toxic with high fever and uremia. A third-year medical student came to my room at 1:00 AM to start another history and physical. I offered to teach him later how to palpate an abdomen if I got well, since his attempt was quite traumatic to me while I was toxic and exhausted.

Intravenous therapy was administered for a four-week period and I required venipunctures two or three times a day for chemical studies. I found the IV teams excellent venipuncture artists but did find it a bit harassing when a medical student had difficulty sticking my anticubital artery for blood-gas determinations. I have always been willing to use myself and my patients to teach medical students and housestaff (having used my own renal biopsy slides for this purpose) but this must be tempered with compassion.

The only other sour note in my hospital stay was the long, grueling stretcher trips to the X-ray Department (I had many chest and extremity X-rays). Getting off and on the stretchers alone were exhausting experiences. The treatment I received from X-ray technicians left much to be desired and was certainly less than humane. I was pushed around on the table like a side of beef. Indeed, this experience was the most traumatic of my hospitalization. I do hope that radiologists and technicians who read this will show their patients more gentleness and perhaps spare them a similar experience.

It was during the course of this hospital confinement that I was told I needed dialysis. I resisted and balked and asked for time to think it over. Because of my own lack of knowledge, I envisioned dialysis as a horrible and undesirable treatment. Had I known more about this therapy and its accomplishments, I could have saved myself many hours of unnecessary agony.

For those who read this and are advised to have hemodialysis, I urge you not to hesitate or object to its great wonders. It is not psychologically or physically painful and it is certainly life-saving. New dialysis equipment and techniques

are constantly progressing as instrumentation is miniaturized and improved. The recent advances in chemical, pharmacological, technical, and electronic phases of nephrology, transplantation, and hemodialysis are nothing less than phenomenal. Hopefully, transplantations and other advances will make the present machines obsolete.

Having agreed to undergo hemodialysis, I was taken to the operating room. The stretcher trip to the OR provided an incomparable time for contemplation. Once there, it felt a bit odd for this surgeon to be occupying the patient's position on the operating table. The surgeons implanted a silastic (Scribner) shunt in the radial artery and nearby vein of my right forearm to provide blood access avenues for dialysis. This was performed under local anesthesia without pain or incident.

Some months later, also under local anesthesia, an AV fistula was established in my left wrist to arterialize and enlarge the veins as a source of blood for dialysis. The anticipation of having a shunt and fistula implanted caused unnecessary apprehension. This was not traumatic nor unpleasant but skillfully performed without pain or immediate unpleasant symptoms.

My initial experiences with dialysis were slightly upsetting, but not for long. The complicated machine, particularly the buzzer-alarm systems, required some adjustment on my part. Unfortunately, I had a reaction interpreted as probable pulmonary embolization which produced some discomfort and apprehension initially. Coumadin was then added to the long list of drugs I was receiving. Blood transfusions were also required for my dropping hematocrit.

After my first few dialysis sessions, I experienced a "washed out," debilitated sensation known as "dialysis dysequilibrium." This syndrome, not clearly understood, produces weakness and sometimes a lightheadedness and a unique generalized malaise.

As time went on, the dialysis treatments became less noxious and more tolerable. The symptoms of dysequilibrium disappeared and I felt much better after each dialysis. My desire to live and thrive returned. My interest in patients and friends also returned. I began to read many books and receive visitors. These were uplifting experiences.

Following my wonderful and lifesaving treatment at the Johns Hopkins Hospital, my wife and I joined the excellent Maryland General Hospital home dialysis training program. We were trained to manage the machinery and techniques to perform these treatments at home.



Fig 1: Silastic shunt in right forearm.

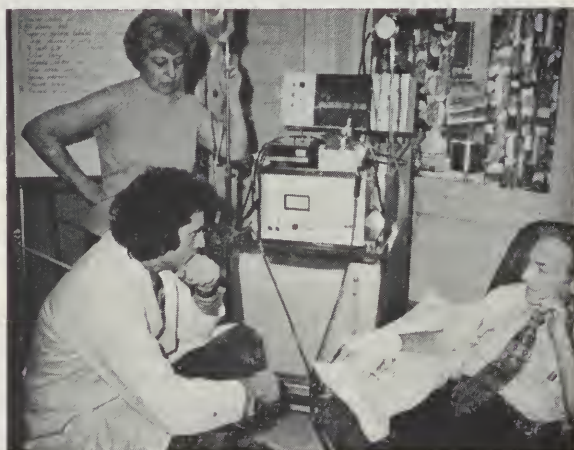


Fig 2: Dialysis training unit, Maryland General Hospital; Dr James Carey, interviewing Dr Kolodner on rounds; Mrs Kolodner in background.

Without my partner (my wife), I doubt if I would have had the strength or will to carry on. What she learned and accomplished is truly extraordinary, especially since she had not received previous nursing or technical training. Although she is a college graduate with a major in chemistry and was elected to Phi Beta Kappa, we did not believe that she was particularly manually dexterous. This was proved to be wrong. She learned to master the intricacies of the dialysis machine: to assemble and disassemble the machine, to connect and disconnect me from the artificial kidney machine (Kolff type), to take blood samples which determine clotting time, and to administer heparin into the tubing. These actions require constant monitoring and an awareness of the pitfalls and complications. Recently, I had a coil rupture while being dialyzed and lost 350 cc of my blood into the machine. My wife was up to this emergency and met it efficiently.

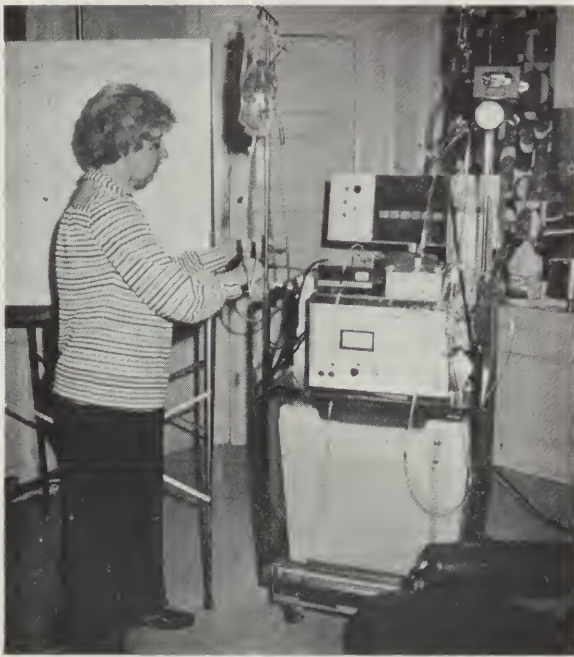


Fig 3: Mrs Kolodner assembling dialysis machine in accordance with instruction sheet in background, a tri-weekly project.

The acquisition of these sophisticated techniques by my wife and many other spouses who are performing these rather awesome functions is nothing less than remarkable. Despite their tremendous love for the patient with kidney failure, the partner's role is fatiguing and tension-producing when performed without periods of rest, diversion, or vacations. It is my feeling that the partner should have periods of relief and relaxation varying from one evening to even a week as the need presents itself. Partners are also susceptible to hepatitis if they come in contact with blood of an infected patient.

Every third evening for a six-hour period, I am on the machine being dialyzed. This allows me to be free and productive in the daytime. While on the machine, I am served my evening meal, make telephone calls, record my blood pressure frequently (using an electronic sphygmomanometer), watch television, read, and receive some friends.

I am active and have returned to consultative surgical practice and minor surgery at present. I am limited to performing minor surgery by the shunt in my right forearm, but I hope to return to doing major surgery when the shunt is removed. I work and teach housestaff and students at Mercy Hospital and serve as physician with the Baltimore City Police Department. Needless to say, I am happy and fortunate to be able



Fig 4: Dr Kolodner being dialyzed in home bedroom for first time as supervised by Mrs Kolodner and Miss Julie Mattimore RN (note refrigerator and storage space in background).

to return to this degree of comfort and productivity. I hope this serves as motivation for those who must contemplate dialysis (or transplantation) as a way of life.

During my convalescence, I first developed a strong yearning for information about renal disease. While confined to bed, I was able to plan a new program for home dialysis patients in Maryland. To this end, I and a group of physicians and nurses are planning and hope to see the fruition of a privately-endowed Home Dialysis Organization (HOMDO).

This nonprofit organization will serve all patients on home or hospital dialysis or those awaiting transplantation, regardless of race, creed, or ability to pay, and will be the only formalized center of its kind in the country. This organization will consist of a director, staff, physicians skilled in all required specialties, nurses, technicians, social workers, and dietitians. These professionals will provide services instrumental in rehabilitating the patient with renal disease. For instance, a very capable and wise dietitian teaches the patient how to conform to diet restrictions and also to "cheat" at times in order to enjoy certain foods without producing harmful effects. All of these services require special training and interest. Hopefully, the HOMDO will offer an excellent training program for all nephrology personnel to meet the needs of the increasing number of patients who will require this therapy.

Across the city and state, all nephrologists and dialysis programs are uniting to support the concept of HOMDO and are working towards its realization. But it will require the help of private and business philanthropy.

Since the initial plans for the program, I have been attending nephrology conferences in

and out of the state as well as reading extensively in this specialty. Indeed this sense of purpose expedited my will to live. I have come to regard my illness almost as a blessing in disguise. I have met the most remarkable people, particularly the mothers and fathers who have donated one of their own kidneys to bring life anew to their children. Their story must be told to awaken the public to the crucial need for kidneys for transplantation and to inform them of the vital activities accomplished by all members of the renal hemodialysis field. This message must reach not only the lay public but the medical profession as well. I urge all physicians to learn more about the advances in nephrology and to visit a dialysis treatment center and a patient on home dialysis. Those who do will find it a fascinating and illuminating experience.

Prominent community leaders have already become involved in this field, such as Mr Jerold Hoffberger, Mr Louis Fox, Mr Joseph Kolodny, Sister Mary Thomas and Dr T Brannon Hubbard of Mercy Hospital, Drs W Gordon Walker, Donald Lewers, James Carey, Robert Levy, Daniel Wilfson, and Mr John Sargeant. I am tremendously indebted to each of these people for their help in our program and their role

in my own return to productivity.

I should also like to pay tribute to the courageous and dedicated nurses and technicians in the dialysis units. They continue to serve unstintingly knowing the alarming high incidence of hepatitis which occurs in personnel working in these units everywhere.

Finally, I must say that there are many facets and requirements for a successful rehabilitation. Visitations and encouragement by my family and friends have helped a great deal as a stimulus to my rehabilitation. Friends who read this article will know who they are for I am most grateful to them all. Other aspects of recovery—medical, physical, dietary, psychological, sociological, and job opportunity programs—are so very essential, but the primary and ultimate motivation must come from the patient.

Our dream of providing a model hemodialysis center for the nation has helped develop my philosophy of life. The very core of this philosophy has been appropriately expressed by the late Robert Frost: "I have promises to keep and miles to go before I sleep." Thanks to medical science and my great physicians, I am able to pursue this goal.



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TRICHINOSIS-THE MARYLAND OUTBREAK OF 1970

John F Aita MD

Morton D Kramer MD

*Dr Aita is with the Department of Pathology, University of Rochester Medical Center, Rochester NY 14642.
Dr Kramer is with St Agnes Hospital, Baltimore Md.*

Information and reprint requests to Dr Aita.

Abstract

A patient with central nervous system, cardiac and hepatic manifestations of trichinosis is presented. The clinical, pathologic and therapeutic aspects of this disease are discussed.

Introduction

Trichinella spiralis is a parasite that may be ingested via undercooked meat products. On the basis of random autopsy sampling and on the basis of reported cases over the past 42 years, we know that there has been a decline in both the prevalence and incidence of trichinosis. During 1971, the last year for which figures are available, there were 115 cases of trichinosis reported with three associated deaths. Traditionally, one associates trichinosis with the ingestion of improperly cooked pork products; certainly this was true during 1971 when 82 (71%) of the cases were traced to pork products. However, 13 (11.3%) of the cases were related to the ingestion of bear meat and 12 (10.4%) cases were felt to be secondary to the ingestion of beef that had been adulterated with pork. No source of infection was identified in the remaining eight cases.¹

Trichinosis may manifest symptoms and signs referable to many parts of the body. The following patient is of interest because of her hepatic, cardiac, and neurologic findings. The neurologic aspects of this case have been previously commented upon (Kramer MD and Aita JF: Trichinosis with central nervous system involvement. *Neurology* 22:485-491, 1972).

Case Report

(Portions of the case report are reprinted with permission of *Neurology*.)

On Feb 4, 1970, the patient (a 17-year-old white girl), her sister, and stepfather had a dinner that included fried pork chops. The pork chops were prepared by placing them first in milk and then in bread and cracker crumbs and frying them for approximately forty-five minutes. The patient had two pork chops, the sister had one, and the stepfather had three, all from the same package. Five days later, the patient was sent home from school because of bilateral conjunctivitis. Later that day, she developed diarrhea and, one to two days later, periorbital edema and a productive cough. Between Feb 10 and 13, she noted the onset of pain and paresthesia over the left side of her body. On Feb 15, 1970, she complained of dizziness and later that day developed weakness of her left arm and leg.

The next day the patient was admitted to a local hospital where she was said to have had the following: oral temperature of 102.6° F, left lateral rectus palsy, and left hemihypesthesia and hemiparesis with left-sided hyperreflexia. She had sustained ankle clonus on the left but no pathological reflexes. Urinary incontinence was present. White blood cell (WBC) counts were reported to show 40% to 50% eosinophils, and a ECG was reported as "sinus tachycardia and Wolff - Parkinson - White syndrome." Results of the cerebrospinal fluid examination were normal. She was transferred to

the University of Maryland Hospital on Feb 20, 1970.

Examination

The patient was mildly obese. She was oriented in all spheres but responded to questioning and commands in a vague manner. Abstract thought and calculations were performed poorly. Insight into her illness varied, and she occasionally denied having any weakness. Blood pressure was 105/55, pulse was 106 beats per minute and regular, and oral temperature was 102.2° F. On general examination, splinter hemorrhages were noted under the fingernail and toenail beds (Fig 1). Mild pain was elicited in both pectoralis major muscles and in both calves only on pressure. There was no periorbital edema; she did not complain of diplopia unless specifically asked and had no pain with eye movements.

Pupils were round and regular and reacted to light. There was a left lateral rectus palsy and a mild left central facial weakness. Asymmetrical quadriparesis with greater weakness on the left, especially in the left leg and foot, was present. Deep tendon reflexes were brisk but increased at both ankles, more so on the left. There was sustained clonus at the left ankle and unsustained clonus at the right ankle. On plantar stimulation, there was plantar flexion of the right great toe but no movement on the left. Sensation and results of cerebellar function tests were normal. She was unable to stand without assistance.

Laboratory Data

The initial white blood cell

Fig 1: Fingernails showing subungual "splinter" hemorrhages (reprinted with permission of Neurology).



TABLE 1

DATE	2/20	2/24	2/26	3/2	3/6	3/9	3/11	3/13	3/16	7/14
<u>PATIENT</u>										
*WBC/mm ³	10,000	9,900	10,800	12,800	11,400	10,700	11,300	11,000	10,100	7,400
% Eosinophils	35	15	15	13	10	16	18	15	17	2
Total Eosinophils/mm ³			1,606			1,903	1,694		1,556	200
<u>SISTER</u>										
*WBC/mm ³								11,500		7,000
% Eosinophils	34							38		3
Total Eosinophils/mm ³								4,136		269
<u>STEP-FATHER</u>										
*WBC/mm ³	10,000									
% Eosinophils	1									

* White Blood Cell

count was 10,000 per cu mm with 35% eosinophils and 1,606 total eosinophils per cu mm; subsequent WBC and eosinophil counts showed the eosinophils to range from 10 to 18% and the total eosinophils from 1,556 to 1,903 per cu mm (Table 1).

Hemoglobin, hematocrit, urinalysis, serology, electrolytes including calcium, blood sugar, creatinine, uric acid, prothrombin time, cholesterol, and blood

urea nitrogen were all within normal limits. Initial liver function studies that were abnormal included: albumin, 2.6 gm%; globulin, 3.2 gm%; LDH (Technicon modification of the Wacker units), 272; and SGOT, 37 Karmen units. These values had returned to their normal ranges two weeks after admission. All other liver function studies were within normal limits, except for BSP^R with 7%

retention after 45 minutes (Table 2).

Serial electrocardiograms showed anomalous atrioventricular excitation (Wolff-Parkinson-White Syndrome) with terminal inversion of the T wave in III and AVF, depression of the S-T segment with a diphasic T wave in I and AVL, and inversion of the T wave in V1-6 (Fig 2). A lumbar puncture and examination of the cerebrospinal

al fluid, X-rays of the chest and skull, and a brain scintogram were normal. The trichinella skin test was positive, and the patient converted from negative to positive with both the latex trichina reagent rapid slide agglutination and the bentonite flocculation test (Table 3). Examination of a left deltoid muscle biopsy specimen showed trichinella spiralis with focal chronic inflammation around one intact parasite and another apparently undergoing absorption.

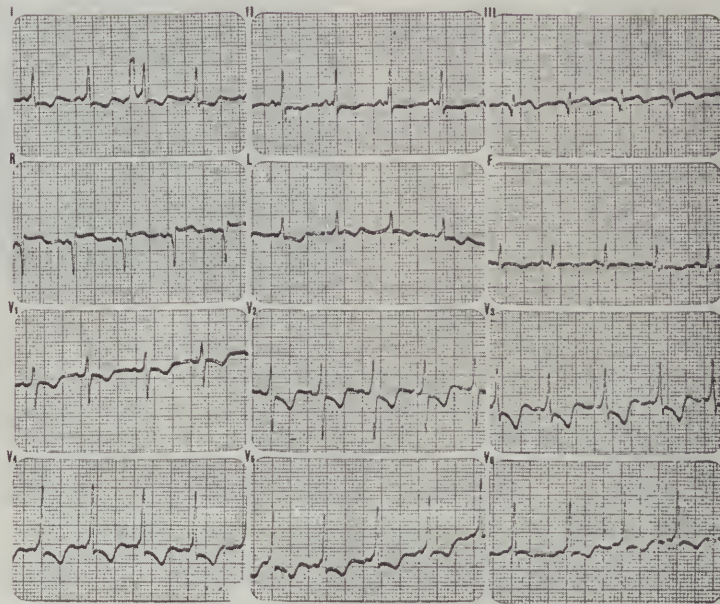
The patient had four electroencephalograms during her hospitalization. The initial electroencephalogram was diffusely abnormal with moderate-to high-voltage slow frequencies occurring bilaterally and symmetrically and with only an occasional eight per second activity appearing posteriorly. Subsequent studies showed progressive improvement with the last tracing showing excessive five to seven per second activity diffusely.

Clinical Course

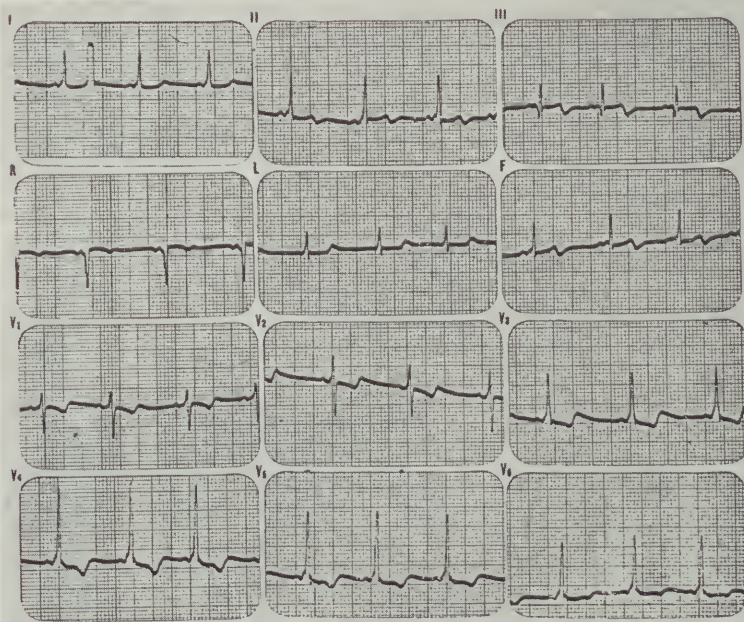
Six hours after admission to this hospital, oral administration of 60 mg of prednisone daily was started. Twenty-four hours later there was no evidence of the left sixth cranial nerve paresis and there was no left facial weakness.

On Feb 24, 1970, the right ankle clonus was not present and that on the left was unsustained. The next day oral administration of 2 gm of thiabendazole (Mintezol®) daily for four days was begun; one day later the urinary incontinence had cleared, the quadripareisis had improved to a mild left hemiparesis, and she was able to walk with the support of a cane. By March 2, 1970, she was able to ascend and descend one flight of stairs, but when discharged 15 days later, she still had a mild left hemiparesis. Prednisone dosage was reduced, and

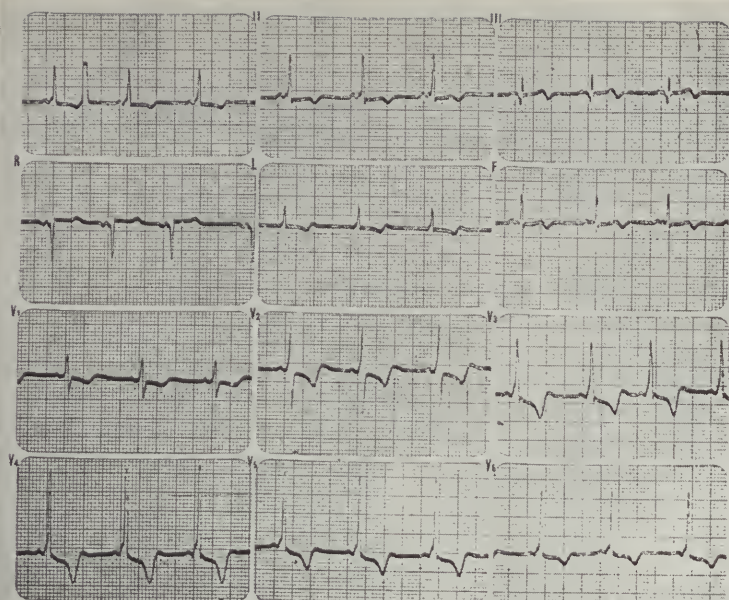
Fig 2: Serial EKGs showing anomalous atrioventricular conduction and ST-T changes:



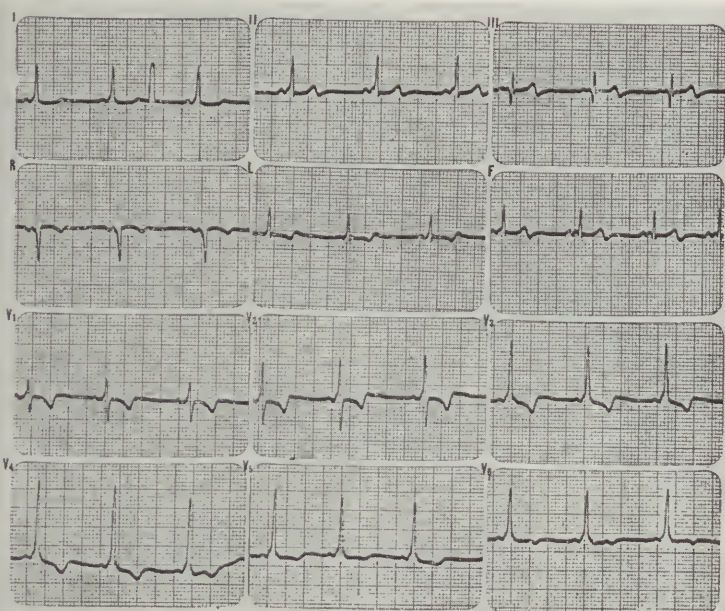
A—Feb 23, 1970



B—March 2, 1970



C—March 9, 1970



D—March 13, 1970

subsequently eliminated, while she recuperated at home. As of June 29, 1970, she still had a mild downward drift of the extended left upper extremity, increased left patellar reflex, and fanning of the left toes to plantar stimulation.

Family

On Feb 9, 1970, the patient's sister also developed bilateral conjunctivitis and later that day was sent home from school because of abdominal pain and cramps. Shortly thereafter, she developed bilateral periorbital edema.

Initial white blood cell count on Feb 20, 1970 showed 34% eosinophils (Table 1). The trichinella skin test was positive, and she converted from negative to positive with both the latex trichina reagent rapid slide agglutination and the bentonite flocculation test (Table 3).

Mintezol was administered orally after she gave a history of pain for the preceding week in both calves and both biceps and near the lower sternal margin on the right. She also described occasional weakness of both quadriceps. When examined on March 15, 1970, she was found to have discrete areas of tenderness over both biceps and both quadriceps.

On the basis of the histories, examinations, and specific laboratory studies, it can be assumed that the patient and her sister had recently acquired trichinella spiralis infection. The stepfather remained asymptomatic.

Parasitology

Trichinella spiralis is a tissue inhabiting nematode that is without an intermediate host. It has been reported to infect 60 species of mammals.²

The disease consists of three phases, the first of which is the gastrointestinal or invasive phase. This follows ingestion of improperly cooked meat containing encysted larvae which are infective only when they are more than 17 days old. The cyst is digested in the stomach, and the larvae migrate to the small intestine where they penetrate the mucosa within one hour, mature, and copulate within 48 hours. During this time, gastrointestinal symptoms may develop. Bearing up to 3,000 motile larvae, the female deposits one larvae every half hour into the mucosa and lymphatic spaces for as long as four months, starting on approximately day ten after ingestion.^{2,3}

The second, or migratory,

TABLE 2

DATE	2/22	2/25	3/2	3/4	3/6	3/9	3/11	3/13	3/15	3/17
<u>PATIENT</u>										
Albumen (grams %)	2.6	2.4	3.2	3.0	2.0	3.0	3.1	3.1		
Globulin (grams %)	3.2	2.7	2.7	2.2	2.3	2.2	2.2	2.1		
Bilirubin (total) (mg %)	.6	.4	.4	.3	.4					
Alkaline Phosphatase (King Armstrong)	10	7	10	9	8	8	7	7		
Thymol Turbidity (units)		5.8				6.3	4.1	4.0		
✓LDH (technicon - modification of the Wacker units)	272	197	231	175	145	121	115	110		
✓SGOT (Karman)	37	37	37	33	26	18	19	18		
Stool for Ova, Cysts and Parasites									Neg	
✓BSP (%)										7%

SISTER

Albumen								3.9		
Globulin								3.0		
✓LDH								156		
✓SGOT								29		

1. Lactic dehydrogenase
2. Serum glutamic oxalacetic transaminase
3. Bromsulphalein; 5% of retention after 45 minutes

TABLE 3

DATE	2/20	2/21	2/22	3/5	3/12	7/14
<u>TRICHINILIA SKIN TEST</u>						
Patient	+	+	+			
Sister			+			
Step-father			Neg			
<u>LATEX TRICHINA REAGENT RAPID SLIDE AGGLUTINATION TEST</u>						
Patient	Neg			4+	4+	Neg
Sister	Neg			3+	3+	Neg
Step-father	Neg			Neg	Neg	
<u>BENTONITE FLOCCULATION TEST</u>						
Patient	Neg			1/640	1/640	1/320
Sister	Neg			1/160	1/160	Neg
Step-father	Neg			Neg	Neg	

phase begins as some of these larvae (which measure 100 x 6 µm) penetrate the small intestine epithelium and migrate outside the circulation, while others are carried through the lymphatics to the thoracic duct where they enter the venous system and are disseminated systemically; very few are lost thru the GI tract. With severe infections, up to 50 million larvae may enter the circulation. The larvae mature in 17 to 21 days, become infective and resistant to peptic digestion, encapsulate, and survive only in skeletal muscle where they may remain viable for the remainder of the host's life or longer; this is the third, or encystment phase.^{2,3}

Clinical

During general dissemination, the following signs and symptoms may develop in addition to the gastroenteritis (first 48 hours) and pneumonitis (2nd week): fever, rash, periorbital and facial edema, myositis, swelling and tenderness of the parotid and sublingual glands, lymphadenopathy, subungual splinter hemorrhages and eosinophilia. Myocarditis may appear after the third week.⁴

Clinically, it is well recognized that 1) there is less tendency for children to acquire trichinosis than adults; or, if they do, the infection is much less severe than in adults; 2) there is a relatively low erythrocyte sedimentation rate (ESR) in trichinosis in the face of a severe inflammatory disease; 3) there is a poor, often fatal, prognosis associated with a low or a sudden fall in the eosinophil count.

Man's fate depends upon the strain and the number of living trichina that he ingests, his individual susceptibility, other pathological conditions, the organs affected and his age.^{2,3}

Complications of trichinosis may be severe, even lifethreaten-

ing and include myocarditis, encephalitis, bronchitis, bronchopneumonia, congestive heart failure, vascular thrombosis, and pulmonary emboli. Most fatal infections are related to the myocarditis and usually occur during the fourth to eighth week.^{2,3}

Electrocardiogram changes may occur during the second week, but are usually seen during the third week and are found in 19.4% to 33% of cases when EKGs have been performed. By far, the most frequently noted abnormality has involved flattening or inversion of the T wave in leads I and II. Other frequent changes include low amplitude QRS complex, atrioventricular or intraventricular block or conduction disturbance. Less frequent abnormalities are depression of the ST segment, sinus arrest, pattern of infarction, bigeminal rhythm, or premature ventricular contractions.⁵⁻⁹

The EKG changes are usually transitory and are felt to be due to a definite anatomic process⁶ and not to a toxic substance.¹⁰ This anatomic process is felt to be the acute, focal myocarditis which results from invasion of the myocardium and the migration through it by the trichinella larvae.^{3,9,11} The larvae which enter the myocardium never encyst there, but rather undergo necrosis or migrate through the heart to the pericardial cavity or the systemic circulation.^{3,8}

On gross inspection of the heart, an increase in the amount of pericardial fluid and petechial hemorrhages into the epicardium and myocardium have been described.¹¹⁻¹³ Microscopically, one may see a widespread, focal, acute myocarditis with disruption and necrosis of cardiac muscle.^{9,11-16} These foci may vary in age and size within the same patient.¹⁴ The inflammatory cell response seen within both the necrotic muscle and the interstitial con-

nective tissue consists of eosinophils, neutrophils, lymphocytes, plasma cells, histiocytes, endothelial cells, a few fibroblasts, and mononuclear cells.^{9,11-14,16} Occasionally, larvae or a portion thereof, may be found outside of blood vessels and muscle fibers,¹⁶ within an area of focal necrosis¹³ or within the pericardial sac.³ In one case,⁹ no larvae were noted on section, but after washing and digestion of the heart, 14 larvae were recovered. These larvae were more mature than those found in the blood and were, thus, not felt to have been within the cardiac blood vessels.

Hepatic manifestations of trichinosis, while seemingly not as common as the neurologic or cardiac involvement do occur and are characterized by abnormalities of liver function as were seen in our patient (Table 2).

Pathologically, fatty changes and degeneration of the liver parenchyma in the periportal and peripheral portion of the hepatic lobule and a cellular infiltrate with endothelial cells, lymphocytes, neutrophils, eosinophils and plasma cells in the periportal regions, and hepatic triades are usually described.^{11-13,15,16} Rarely, have larvae been described either within sinusoids or lying free outside of a vessel within the liver.¹⁶

The histologic changes within the liver do not seem to occur within the first ten days after the onset of signs and symptoms of trichinosis.¹⁵ However, Guattery's Case 4 who died 55 days after the onset of symptoms was found to have hepatomegaly, periportal cellular infiltrate (neutrophils, plasma cells, eosinophils and lymphocytes), a slight increase in periportal connective tissue and a moderate to severe fatty change in the parenchymatous cells predominantly in the periportal and the peripheral portion of the hepatic lobule.¹⁵ Guattery's Case 5 (sister of his Case 4), died 126 days

after the onset of symptoms and was described as having hepatosplenomegaly, ascites and portal cirrhosis with complete destruction of the normal architecture by bands of connective tissue which contained plasma cells and lymphocytes which divided the liver into irregular lobules, marked fatty change of the parenchymal cells, a slight degree of liver cell regeneration, and a few areas of increased number of immature biliary ducts.¹⁵

The hepatic damage is felt to be secondary to one or more of the following factors: a) poor nutrition, nausea, vomiting, or diarrhea; b) direct invasion of the liver by the larvae; c) vascular damage; d) or, perhaps, allergic factors.¹⁵

An antibody response to trichinella spiralis is dependent upon the elaboration and secretion of antigens by the B₁ granules within the stichocyte cell of the parasite. The stichocyte cell and the B₁ granules are present in the adult intestinal parasites and the mature muscle larvae, but are not present in the migrating larvae. Thus, the immune response is directed against the intestinal stages of the disease probably by interfering with the reproductive capacity of the adult female.¹⁷

Therapy

The therapy of a patient with trichinosis is two-fold and should consist of both corticosteroids (or ACTH) and thiabendazole (Mintezol®). The clinical response to the steroid therapy is prompt and their use may prove to be life saving in patients with arrhythmias, congestive heart failure, or in patients with severe cerebral manifestations. The steroids diminish the body's inflammatory response to the larvae and, by doing so in the small intestine, they may result in a prolongation of the time that the female trichina deposits larvae into the mucosa. There-

fore, thiabendazole, an antihelminthic agent, should be administered concomitantly. Thiabendazole is felt to be effective against both the intestinal and the muscle trichina and usually produces subjective improvement within forty-eight hours.^{3,18}

Cathartics are useful only prior to the invasion of the intestinal mucosa by the female trichina.

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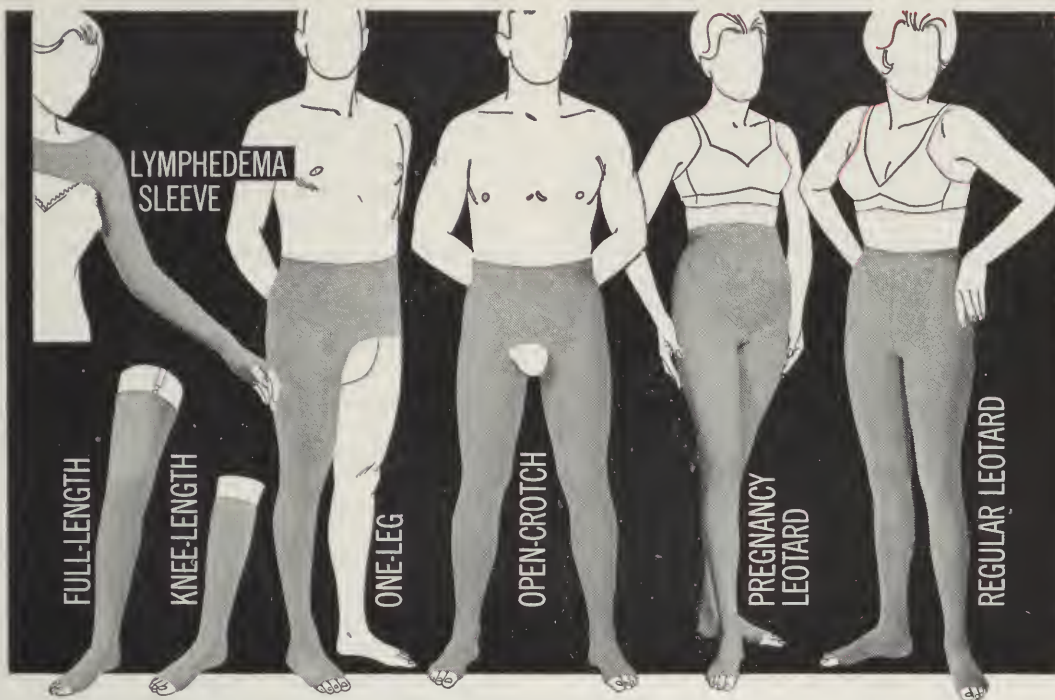
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TO SET THE RECORD STRAIGHT

SAMUEL MORRISON MD

Information and reprint requests to Dr Morrison, 11 E Chase St, Baltimore Md 21202.

In this automated age, a diversity of opinion is more welcome than ever. Even Dr Welby, with his one patient a week, has many problems. Imagine what ours are in the complicated real world of today. It is a world where aggressive and innovative ideas are welcome, even controlled opportunistic ideas.

However, in our efforts to do a good job, the practice of medicine was never meant to be a financial bonanza, and the younger groups in the medical profession have no right and should not counteract the apparent efforts of their peers to control extravagant overusage by the accusation that the older and more experienced are not "with it" in terms of modern, up-to-date practice. The gentility of approach, the understanding and the nonabrasiveness of the older doctor is a lesson in itself.

The crisis in America's health care demands mature and temperate consideration. This is not being resolved quickly enough but, in fact, is being complicated by the fantastic rise in the cost of health care, for it remains true that a severe illness may be ruinous to a middle-income family. Therefore, in censoring the overuse of tests and various procedures, I do not mean to censor or criticize the procedures themselves, but rather the practitioner who overdoes. This is costly and offensive in terms of the rational practice of medicine.

Basically, the duplication and performance of noncontributing tests and procedures should be condemned. Man's main problem with any new and accepted technique is its regulation. Only the wisdom of the more experienced can best decide how to use these new devices and this new technology. A group of objective observers could review any series of charts and come to the conclusion that too much of the material in them is not helpful in terms of diagnosis and treatment, that there are too many repetitious tests, that some are done to prove what was already apparent, and, so, in this noncontributing area, the cost of medical care goes up.

Therefore, many of us feel we have a moral obligation to correct this trend, this evidence of poor practice, this evidence of not taking time to assimilate what has already been done.

I, for one, cannot abrogate this responsibility. If I do so, I would feel guilty of lack of knowledge and leadership. In undertaking this responsibility, the effort has to be critical, but is not criticism except in a guiding sense.

I think it is a good thing to have an open debate on the subject. In essence, we agree to move forward, which is a real achievement, and it should be a harmonious one. It is to be looked upon as a corrective and nonpunitive approach—an educative approach. Most of us will live and learn; some never do. But the past idea that experience is a good teacher cannot be refuted. Incidentally, this does not mean that any of us are focused on any one procedure. It only means that an example is picked in an earnest effort to correct the excesses, and, in this way, to assure a continuum of the educational process.

The broad topic of too many tests has been brought to the profession's attention, and I hope it has reached a level of professional and financial evaluation which, if realized, will be a real accomplishment in terms of ourselves as individuals and our profession as a whole. Patients will benefit by more attention in the way of individual evaluation and, certainly, health costs will be diminished.

A sense of purpose must be restored to the profession as a whole. The purpose for most of us is to take care of patients and this, in my judgment, does not mean exposing them to endless tests. In doing this, I am not preoccupied with this topic alone, but I am very seriously viewing it as a protagonistic effort. The matter of too many tests is not a local problem. It is a problem all over the United States and, therefore, a title such as *Too Many Tests? Prove It* (Open Forum, Oct 1972) is an anachronism and does not deserve serious consideration. So obvious is it that one of our forward-looking hospitals, Maryland General, has applied to each chart a sticker asking the doctor, including the attending, the house staff, and students to help lower patient's hospital costs (Table 1).

It indicates where to check and how to familiarize oneself with the work-up so as not to be guilty of repetition. The reader must understand that this is not a matter of deciding who is right, but what is right; I hope in this area we are actually protagonistic in a very vital effort. In order to make a contribution, there is no room for abrasiveness or personal conflicts. If ever a statesman-like approach was necessary, it applies here.

On the whole, the article in the October 1972

TABLE I
DOCTORS
(ATTENDINGS — HOUSESTAFF —
STUDENTS)

HELP DECREASE YOUR PATIENTS'
HOSPITAL COSTS

DON'T REPEAT LAB TESTS
ALREADY ORDERED

PLEASE CHECK:

1. EMERGENCY ROOM RECORDS
2. ADMISSION SHEETS (Especially for chest X-rays and EKGs)
3. DOCTOR'S ORDER SHEETS (Blood drawn in donor station is marked off on page one)
4. THE PATIENT (Some of the work-up may have been done as an outpatient)

**HOUSE OFFICERS AND STUDENTS
WHEN YOU TAKE OVER A CASE IN PROGRESS**

1. CHECK CARDEX
 2. CHECK LAB REPORTS ON THE CHART
 3. READ **ALL** PREVIOUS ORDER SHEETS (Some studies may be scheduled or in progress)
 4. IF UNFAMILIAR WITH PATIENT'S WORK-UP — Check with appropriate resident or attending **BEFORE** ordering additional X-rays, EKGs, chemistries, scans, etc.
-

issue of the *Maryland State Medical Journal*, emanating from the Chairman of the Med-Chi Peer Review Committee, is a welcome one. It represents an interchange, but no amount of rhetoric, such as in that article, can get around the objective for which I am striving. Those who have read the series of articles (mine and others) must come to their own judicial conclusions and act for the good of the profession. We must not be afraid to rock the boat, even in self-criticism, for we doctors *are* contributing to the spiraling costs of medical care, and we must recognize this. The prestige of our profession is at stake. As many of you know, the Health Service Cost Review Commission of the State Department of Health and Mental Hygiene is undertaking a survey which, I believe, will go beyond hospital costs, and will include some of the fantastic incomes which some medical men are earning.

When a costly procedure (say endoscopy) is done too often, it is not the procedure which is being criticized, but the frequency of its use. Realizing the numerous and sophisticated instruments which are now available, there will be more areas in which to use them, but I would

introduce the rule that these areas must be justified. For those of us who are critical, let me suggest that the clinical acumen to avoid a procedure requires much more time and consideration than does the performance of a procedure.

Dr Theodore E Woodward, Professor of Medicine at the University of Maryland Medical School, has written me that he is constantly trying to inculcate the impression in the teaching of medical students and house officers, as well as faculty, about the frequency of testing and how he asks: Is this test necessary and do you need this information for the comprehensive care of the patients? Dr Lawrence E Serra, formerly Chief of Medical Service at St Joseph Hospital, has allowed me to use his name in this same effort since he, too, was impressed with the over-usage of procedures, such as gastroscopy. There are those who write and argue well, but who remind me of Shakespeare's quote: "The lady doth protest too much." This brings up the thought as to what kind of world this would be if every one decided not to get involved. There is a Latin quotation, "Quis custodiet, isto custodes?" Translated it means, "Who will guard those very guards?"

The practice of a physician, as an individual or in a group or organization, must be ruled acceptable to the public as well as in the eyes of his peers. I sometimes cannot understand that type of mind which requires scientific proof for what he accepts. How would the religious people and the philosophers react to this? Is everything so finite that scientific proof is necessary? It has been noted that some people use statistics as a drunken man uses a lamp post—for support rather than illumination. We must avoid the development of any cult which relies on numerous tests or gadgetry rather than the careful health review which comes from the physical examination and listening to the patient's problems.

In reviewing the article in the October 1972 issue of the *Maryland State Medical Journal*, I avoid the simplistic thought that there is a pet grievance and that any unrest arises from a pet grievance; it is, as I stated, the total problem which concerns me and what is mentioned as a "pet peeve" is only one concern in the area of excessive usage. Again, this does not condemn the procedure, but the excessive use of it and, as stated before, the cost involved, the necessity for it, and the contribution it makes. I do not believe there is any weakness in my argument and in the format presented, one is not presenting a scientific paper, but rather a logical set

Have you ever seen a realistic chart on food cholesterol?

Do you consider shrimp to be low in cholesterol and butter to be high? Actually, there's 12-1/2 times as much cholesterol in a 3-1/2-ounce (100 grams) serving of shrimp as there is in a teaspoon pat (5 grams) of butter! The chart below on cholesterol content of various foods takes normal servings into account.

MEAT, FISH AND EGGS

	Cholesterol (mg)
Liver (3-1/2-oz. serving-cooked)	438
Eggs (1 large)	252
Oysters (6 to 9 Pacific Small Meat only)	120
Lobster (3-1/2-oz. serving)	85
Shrimp (10 small)	150
Clams (10-meat only)	60
Veal (3-1/2-oz. serving) ..	99
Pork (3-1/2-oz. serving) ..	88
Beef (3-1/2 oz. serving) ..	91
Lamb (3-1/2 oz. serving) ..	100
Fish (3-1/2 oz. serving) ..	50-60
Chicken (3-1/2-oz. serving) ..	87

DAIRY FOODS

Whole milk (8-oz. glass) ..	34
American cheese (1 oz.) ..	28
Ice Cream (1/4 pint)	27-43
Heavy Whipping Cream (1 tbsp.)	20
Creamed cottage cheese (1/2 cup)	11-24
Butter (1 pat)	12
Gouda cheese (1 oz.)	21
Yogurt (1/2 cup)	8
Half and half (1 tbsp.)	6
Skim milk (8-oz. glass) ...	5

Cholesterol Values from:

Journal of the American Dietetic Association: Feeley, R. M. et. al.; "Cholesterol Content of Foods"; 61:134, August 1972.

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of thoughts which are to be read and evaluated and hopefully used to good purpose.

The point of my effort revolves again around the topic of too many tests. This is pointed out in the original statement of the Peer Review Committee and its chairman in the April 1971 issue of the *Maryland State Medical Journal*, which reads: "Individually, we have wrung our hands and berated rising hospital costs, unnecessary admissions, and prescribing or 'shooting the works' in ordering X-rays or laboratory services. It is always the other guy, never ourselves, who is guilty of such practices. We have overlooked the fact that it is the individual physician who admits and discharges the patient, and who orders the services the patient receives. The services we order and the competitive gadgetry we demand at our hospitals are major factors in cost escalation." Let those who write these words heed them.

In other words, in the language of the Peer Review Committee, the overuse of tests is acknowledged. In their activities they admit this, but then the article of October 1972 is entitled, *Too Many Tests—Prove It!* What kind of double talk is this? In fact, in all the recent reviews the same objective is preached and is considered to lead to better practice and better health care (to which I would add at a reasonable cost). Let me ask how many of my readers know the cost of a fiberoptic gastroscopy with and without biopsy? Dr George E Burch, Professor of Medicine at Tulane and Editor of the *American Heart Journal* has expounded similar views in a recent Editorial (*Amer Heart J* 85:291, March 1973).

Finally, the statement that we are looking for a cooperative effort by all physicians is the most agreeable thought that can be advanced. Above all, we cannot be above the line of battle. We are definitely in it and we have made our very real contribution to the spiraling cost of medical care. We must learn to control ourselves in ordering tests and using our various machinery. Analytical devotion of the doctor in consultation with others will, in many cases, reduce the number of tests and would, in most cases, be more beneficial to the patient.

Let us keep three thoughts in mind: 1) The physician is the most essential part of the medical team, not the instrument; 2) Insure that services rendered patients are medically necessary and are provided in accordance with professional standards; and 3) The cost of medical care is *our* concern, a concern which cannot be delegated to others.

MARYLAND STATE MEDICAL JOURNAL

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Past pill experience

Known special hormonal needs

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Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain¹⁻³ leading to this conclusion, and one⁴ in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll³ was about sevenfold, while Sartwell and associates⁴ in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of

fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfolobomphthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969.

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MINUTES

First Meeting, 175th Annual Session, House of Delegates

(277th Meeting)

Medical and Chirurgical Faculty of the State of Maryland

Wednesday, April 25, 1973

Baltimore Civic Center, Baltimore Md

The 277th meeting, first of the 175th annual session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was called to order at 9:40 AM, Wednesday, April 25, 1973, at the Baltimore Civic Center, Baltimore Md, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Doctors

Manning W Alden, Council
Sergio Alvarez-Velasco, Anne Arundel Co
*Ian R Anderson, Baltimore City
Charles Bagley III, Wicomico Co
Timothy D Baker, Baltimore City
John G Ball, Council
Richard D Bauer, Past President
Joseph I Berman, Baltimore City
Emidio A Bianco, Baltimore City
Katherine H Borkovich, Council
M McKendree Boyer, Council
Henry A Briele, Past President
James B Brooks, Council
*John M Buchness, Baltimore City
*William R Campbell, Wicomico Co
D Delmas Caples, Baltimore Co
James D Carr, Baltimore City
John T Chissell, Council
Peter Chodoff, Baltimore City
*Thomas C Cimonetti, Howard Co
Kenneth Cruze, Montgomery Co
William B Culwell, Carroll Co
Richard Y Dalrymple, Council
Henry V Davis, Cecil County
Melvin B Davis, Baltimore Co
John B De Hoff, Baltimore City
DeWitt E DeLawter, President, Council
John M Dennis, Council
Michael Dobridge, Montgomery Co
Wm Carl Ebeling, Council, President-elect
Wolcott L Etienne, Council
Robert W Farr, Kent Co
*Edward Feroli, Montgomery Co
George G Finney Jr, Balto City
Vincent J Fiocco Jr, Carroll Co
Russell S Fisher, Council
Ronald H Fishbein, Baltimore City
Elliott R Fishel, Baltimore City
Harold H Gist, Washington Co
Gina M Glick, Allegany Co
I. Michael Glick, Allegany Co
Robert B Goldstein, Council
Edward G Grau, Baltimore Co
George H Greenstein, Baltimore City
Joseph B Gross, Baltimore City

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J Roy Guyther, St Mary's Co
John Collins Harvey, Council
William G Helfrich, Baltimore City
Thomas Franklyn Herbert, Howard Co
Philip W Heuman, Council
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*Gerald A Hofkin, Baltimore City
*John C Hyle, Baltimore Co
*M Inayat, Baltimore City
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Leon R Levitsky, Prince George's Co
*Kenneth B Lewis, Baltimore Co
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Donald W Mintzer, Baltimore City
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*Arturo M Monteiro, Charles Co
*Frederick Moomau, Montgomery Co
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George R Spence, Montgomery Co
Raymond P Srsic, Anne Arundel Co
Osmar P Steinwald Jr, Balto City
*Oscar C Stine, Baltimore City
*Edward L Suarez-Murias, Balto City
*Richard M Susel, Baltimore City
Robert J Thomas, Council
Francis J Townsend Jr, Council
Richard F Tyson, Baltimore City
*John B Umhau, Montgomery Co
*Hewitt I Varney, Montgomery Co
William C Weintraub, Prince George's Co
*Walter R Welzant, Baltimore City
Merton L White, Montgomery Co
Roger Gilbert Windsor, Baltimore Co
Henry M Wise Jr, Montgomery Co
Charles E Wright, Frederick Co
*R Lane Wroth, Talbot Co
*Robert W Zimmerman, Montgomery Co
Present also were staff personnel.

Invocation

Karl F Mech MD, Treasurer of the Faculty, gave the invocation.

Announcements

The President made several announcements regarding the manner of conducting the business of the session.

Minutes

The minutes of the House of Delegates, semiannual session, Ocean City Md, held on Saturday, Sept 15, 1972, having been distributed to all members and having been approved by the Executive Committee, were presented to the House for information.

Introduction of Guests

Joseph A Elliott MD, President, Medical Society of Delaware; William J D'Elia MD, President of the Medical Society of New Jersey; and Worthy W McKinney MD, President, West Virginia State Medical Association, were all introduced to the House.

Necrology

After the Secretary read the following names of deceased members, the members of the House of Delegates rose in observance of a moment's silence in respect for their deceased colleagues:

Allegany County

Whitworth, Fuller B June 14, 1972

Anne Arundel County

Bullwinkel, Henry G Sept 9, 1972
Weitzman, Frances Edith Sept 22, 1972

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Baltimore City

Anderson, Walter Anders	Oct 11, 1972
Artigiani, Philibert	Dec 28, 1972
Baetjer, Walter A	Aug 24, 1972
Bagusin, Alexis M	Feb 15, 1973
Browne, Raynor	Jan 2, 1973
Buettner, Henry F	May 3, 1972
Collins, James M	Dec 13, 1972
Eastland, J Sheldon	April 20, 1973
Frey, E William	April 15, 1972
Goldman, Harris	Jan 26, 1973
Goodman, Jerome E	Feb 9, 1973
Hachtel, Frank W	July 13, 1972
Hunt, Richard Henry	March 13, 1972
Insley, James K Jr	Oct. 6, 1972
Kress, Milton B	March 7, 1973
Lowman, Milton Edward	June 22, 1972
Miller, Jacob M	Sept 4, 1972
Moore, James I	Dec 16, 1972
Naquin, Howard A	Sept 21, 1972
Ogden, Frank N	April 17, 1972
Rao, Palem S	April 20, 1972
Ruzicka, F Fred Sr	Aug 3, 1972
Schaffer, Louis Hutzler	Feb 4, 1973
Schiff, Hyman	April 26, 1972
Shepperd, J Douglass	June 29, 1972
Siegel, Charles I	Nov 6, 1972
Siver, Robert H	June 4, 1972
Spence, John M	April 10, 1973
Sunday, Stuart D	Sept 17, 1972
Tan, Manuel Jabines	June 4, 1972
Tramer, Arnold	May 21, 1972
Weinstock, Alexander A	May 7, 1972
Wice, Louis E	June 14, 1972
Zinn, Waitman F	Dec 27, 1972

Baltimore County

Brouillett, George H	March 3, 1972
Cordi, Joseph M	Nov 9, 1972
Hening, R M	Dec 3, 1972
Michelson, Alfred	Aug 19, 1972
Royce, Paul	March 24, 1973

Carroll County

Billingslea, Charles L	Feb 19, 1973
Gross, Martin	Jan 17, 1973
Lawson, William H Jr	Nov 1, 1972

Cecil County

Cantwell, H A	Dec 20, 1972
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Howard County

Phillips, Frederick	April 5, 1972
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Kent County

Whitsitt, Anderson F	Aug 21, 1972
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Montgomery County

Bergstrom, Roger H	Nov 11, 1972
Edenbaum, Richard Harris	Oct 17, 1972
Kellogg, Donald A	Jan 10, 1973
Laughlin, Kenneth F	Dec 31, 1972

Prince George's County

Bachrach, Louis B	June 21, 1972
O'Donovan, Timothy F	Feb 3, 1973
Szollasi, Etienne	Aug 10, 1972
Van Natta, Paul	Jan 30, 1973

St Mary's County

Houser, Alan D	Sept 2, 1972
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Somerset County

Barr, A N	Sept 1, 1972
Coulbourn, George C	June 1, 1972

Washington County

Bowman, Harry D	June 9, 1972
Cohen, Archie R	March 7, 1973
Hiehle, Wilbur W	March 24, 1972

Wicomico County

Fritz, William C	Feb 18, 1973
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Affiliate

Day, J Ronald Jr	Jan 23, 1973
------------------	--------------

Presentation of 50-Year Pins and Certificates

The President awarded a 50-year pin and certificate to the following member who was present for the meeting:

Herman J Dorf MD, Baltimore

Fifty-year certificates and pins will be mailed to those members unable to be present:

Edwin N Broyles MD

Val L Ellicott MD

Nathan B Herman MD

Moses Paulson MD

Daniel J Pessagno MD

William F Rienhoff Jr MD

George E Shannon MD

all of Baltimore

Richard W TeLinde MD, Lutherville

Horace F Kline MD, Frederick

Gerald W LeVan MD, Boonsboro

Louis Sachs MD, Pompano Beach Fla

Emeritus Membership

On motion of Council Chairman Dr Alden, the following members who had received the recommendation of their component societies and the Council were elected to Emeritus Membership in the Faculty:

Anne Arundel County Medical Society

Robert R Hahn MD, Severna Park

Baltimore City Medical Society

William C Dunnigan, Baltimore

F A Pacienza MD, Baltimore

Harry N Rudin MD, Baltimore

William Schuman MD, Baltimore

Carroll County Medical Society

Robert S McVaugh MD, Taneytown

Howard County Medical Society

Theodore R Shrop MD, Ellicott City

Montgomery County Medical Society

Henry W Jaeger MD, Silver Spring

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1776
Franciscan Father Francisco Garces established missionary ranch

1821
Mexico gained independence from Spain; territory became New Mexico

1848
United States gained territory from Mexico

1886
Colan Campbell homesteaded 80,000 acres adjoining Ash Fork

1929
Campbell Ranch incorporated into Ash Fork Livestock Company, identified by Bar-Z-Bar brand

1971
Campbell estate sold Campbell Ranch to Arizona's Juniperwood Ranch

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Talbot County Medical Society

Shepard Krech Jr MD, Easton

Washington County Medical Society

M C Smoot MD, Hagerstown

At Large

Lester W Harris MD, Ocean City

Adoption of Resolution

Dr Alden, on behalf of the Council, moved adoption of the following resolution, which was adopted and reads as follows:

Resolved, That the membership of this Society be informed that the Medical and Chirurgical Faculty has taken no official stand to date on PSRO as embodied in HR1 (the Bennett amendment); and
Resolved, That in the ensuing months every effort of our Society and its members be expended to acquaint themselves with the law and its (as yet unpublished) regulations so that an informed decision may be made at the appropriate time.

Memorial Resolutions Adopted ARCHIE R COHEN MD

The Secretary offered the following memorial resolution which was adopted unanimously:

WHEREAS, An illustrious and noble colleague died on March 7, 1973; and

WHEREAS, Archie R Cohen MD, of Clear Spring Md, exemplified the perfect family physician; and

WHEREAS, Over the years in his practice he gained the respect and admiration of his patients, colleagues and friends; and

WHEREAS, He served the profession to the utmost degree in many capacities never refusing to act on behalf of his fellow-physicians in serving the common good; and

WHEREAS, Archie, as he was known to his many friends, worked unstintingly in improving the quality of health care available to the public and untiringly on behalf of his patients; and

WHEREAS, Such devotion deserves recognition beyond that accorded to many physicians, be it

Resolved, That this House of Delegates at its regular convened session on Wednesday, April 25, 1973, takes note of these accomplishments of Archie R Cohen MD, and expresses its sorrow to his relatives on the occasion of his death, and be it

Resolved, That a copy of this resolution be spread upon the minutes of this meeting and sent to Mrs Esther Cohen thus expressing, in a limited manner, the feelings of this House.

J SHELTON EASTLAND MD

The Secretary offered the following memorial resolution which was adopted unanimously:

WHEREAS, J Sheldon Eastland MD, died on Friday, April 20, 1973; and

WHEREAS, During his lifetime he served as professor, confidante, teacher and friend; and

WHEREAS, He served his fellow physicians as Faculty President, as Delegate to the AMA House of Delegates, as a member and Chairman of the Blue Shield Board and in many other capacities; and

WHEREAS, It is fitting that because in his lifetime he abhorred attention being paid to his accomplishments, he now be honored by this House of Delegates; be it therefore,

Resolved, That this House of Delegates in memory of his death observe a moment's silence in his memory; and be it

Resolved, That a copy of this resolution be spread upon the minutes of this meeting, Wednesday, April 25, 1973, and sent to his widow.

Treasurer's Report and 1973 Budget

Karl F Mech MD, Treasurer, presented the 1973 budget for information of the House, this having been adopted by the Council. The Treasurer advised that the Faculty's books had been audited and by unanimous consent the report of the CPA was approved.

Bylaws Committee Report

Charles F O'Donnell MD, Chairman of the Bylaws Committee, on its behalf, moved the adoption of the following bylaws amendments which, after debate, were adopted in each case by more than the required two-thirds vote:

Amend Article II (Membership) Section 2 (b) after "(2)" and before "and (5)" by inserting "(3)".

Amend Article III (Finance) Section 1 (b) by substituting for it the following:

"(b) FOR ASSOCIATE MEMBERS: \$25.00 provided however that for those described in Article II, Section 2 (7) the dues shall be negotiated annually for all members of the Baltimore City Dental Society on a group basis."

Amend Article XI, Section 18 by substituting for it the following:

"Section 18. AN OCCUPATIONAL HEALTH COMMITTEE of at least five members shall study and report as it deems advisable upon all phases of occupational health including the working environment. It shall consider such subjects as occupational health problems in industry; and the quality and health environment in industry, as it affects the working man. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President."

Nominating Committee Report

John F Schaefer MD, Chairman of the Nominating Committee, presented the following slate:

President-elect

Manning W Alden, Annapolis
(President-elect 1973-74)
(President 1974-75)

First Vice President

J Parran Jarboe, LaPlata (1975)

Second Vice President

William G Speed III, Baltimore (1975)

Third Vice President

Robert G Angle, Bethesda (1975)

Secretary

William A Pillsbury, Timonium (1975)

Treasurer

Robert B Goldstein, Baltimore (1975)

Councilors

Central District

Albert M Antlitz, Baltimore (1977)
Joseph I Berman, Baltimore (1977)
Katherine H Borkovich, Baltimore (1977)
James B Brooks, Baltimore (1977)
John R Davis Jr, Baltimore (1973-76)
Roland T Smoot, Baltimore (1977)

Eastern District

E Kent Carney, Salisbury (1977)

South Central District

Francis C Mayle Jr, Bethesda (1977)
Barry Rosenberg, Hyattsville (1977)
Merton L White, Silver Spring (1977)

Southern District

Henry L Burke III, LaPlata (1977)

Western District

Herbert H Leighton, Oakland (1973-76)

Delegate to the American Medical Association

Charles F O'Donnell, Towson
(Jan 1, 1974 — Dec 31, 1976)

Alternate Delegate to the American Medical Association

John M Dennis, Baltimore
(Jan 1, 1974 — Dec 31, 1976)

Committee on Program and Arrangements

Sheldon C Kravitz, Baltimore (1974-78)

Library and History Committee

Margaret L Sherrard, Baltimore (1974-79)

Finney Fund Committee

Richard V Hauver, Hagerstown (1974-79)

Board of Medical Examiners

John E Adams, Towson (June 1973-June 1977)
DeWitt E DeLawter, Bethesda (June 1973-June 1977)

The floor was opened to further nominations for these offices and there being none, nominations were closed by general consent, the election to be held at the second meeting of the session, Friday, April 27, 1973, at the Faculty Building, at 2:00 PM. The Board of Medical Examiners are to be elected at the General Session, Thursday, April 26, 1973, at the Baltimore Civic Center, at 12 Noon.

Brief Recess

By unanimous consent, the President declared a brief recess of the House of Delegates, at 10:20 AM, and reconvened the House at 10:45 AM.

Russell B Roth MD, President-elect of AMA, Addresses the House

The President introduced Russell B Roth MD, President-elect of the American Medical Association, who addressed the House following a brief film presentation. Following his address, seedlings were distributed to members of the House.

Adjournment

There being no further business, the President declared the meeting adjourned until Friday, April 27, 1973, at 2:00 PM at the Faculty Building.

WILLIAM A PILLSBURY MD, Secretary

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MINUTES

Second Meeting, 175th Annual Session, House of Delegates

(278th Meeting)

Medical and Chirurgical Faculty of the State of Maryland

Friday, April 27, 1973

Faculty Building

The 278th meeting, second of the 175th annual session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was called to order at 2:10 PM Friday, April 27, 1973, at the Faculty Building, 1211 Cathedral St, Baltimore Md, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors

Manning W Alden, Council
Charles Bagley III, Wicomico Co
Timothy D Baker, Baltimore City
John G Ball, Council
Richard D Bauer, Past President
Joseph I Berman, Baltimore City
Norman K Bohrer, Prince George's Co
Katherine H Borkovich, Council
M McKendree Boyer, Council
James B Brooks, Council
*John M Buchness, Baltimore City
Robert vL Campbell, Council
*William R Campbell, Wicomico Co
James D Carr, Baltimore City
Peter Chodoff, Baltimore City
*Thomas C Cimonetti, Howard Co
Joseph R Cowen, Baltimore City
Kenneth Cruze, Montgomery Co
John B De Hoff, Baltimore City
DeWitt E DeLawter, President, Council
Marshall A Diamond, Montgomery Co
Wm Carl Ebeling, Council, President-elect
Wolcott L Etienne, Council
John F Eyring Jr, Balto City
Robert W Farr, Kent Co
George G Finney Jr, Balto City
Vincent J Fiocco Jr, Carroll Co
Elliott R Fishel, Baltimore City
Russell S Fisher, Council
Harold H Gist, Washington Co
Robert B Goldstein, Council
*Martin K Gorten, Baltimore City
George H Greenstein, Baltimore City
Joseph B Gross, Baltimore City
William G Helfrich, Baltimore City
Charles Earl Hill, Anne Arundel Co
John H Hirschfeld, Baltimore City
*Gerald A Hofkin, Baltimore City
*M Inayat, Baltimore City
J Parran Jarboe, Council
D Frank Kaltreider, Council
Bernard S Karpers Jr, Balto City
Arthur T Keefe Jr, Council
Seruch T Kimble, Council
*Marvin L Kolkin, Montgomery Co
*Edward L J Krieg, Baltimore Co

Doctors

Edwin R Lamm, Prince George's Co
William T Layman, Washington Co
Herbert H Leighton, Garrett Co
Leon R Levitsky, Prince George's Co
J Richard Lilly, Prince George's Co
Elmer G Linhardt, Bd of Med Exam
Allan H Macht, Baltimore City
Jose Martinez, Baltimore City
Francis C Mayle Jr, Montgomery Co
*Robert B McFadden, Baltimore Co
Karl F Mech, Treasurer, Council
Ernest B Miller, Univ of Md Student
Donald W Mintzer, Baltimore City
*Paul A Mullan, Baltimore City
Charles F O'Donnell, Council
Hilary T O'Herlihy, Anne Arundel Co
Eugenie E Phillips, Balto City
William A Pillsbury, Secretary, Council
Carolyn H S Pincock, Council
*Fausto M Prezioso, Balto City
J Emmett Queen, Balto City
William Reichel, Baltimore Co
*Jimmie Lee Rhyne, Baltimore City
Seymour H Rubin, Baltimore City
John F Schaefer, Council
J Thomas Schnebly, Montgomery Co
Edyth Hull Schoenrich
George Sharpe, Montgomery Co
Margaret Lee Sherrard, Balto Co
*Edward L Sherrer Jr, Balto City
R Kennedy Skipton, Prince George's Co
Elizabeth B Sherrill, Baltimore Co
William G Speed III, Council
George R Spence, Montgomery Co
Raymond P Srsic, Anne Arundel Co
Osmar P Steinwald Jr, Balto City
*Oscar C Stine, Baltimore City
*Edward L Suarez-Murias, Balto City
*Hewitt I Varney, Montgomery Co
*B B Velez, Baltimore Co
Sidney J Venable Jr, Balto Co
William C Weintraub, Prince George's Co
*Philip Whittlesey, Baltimore City
Roger Gilbert Windsor, Baltimore Co
Charles E Wright, Frederick Co
Present also were staff personnel.

Introduction of Guests

The President introduced Robert S Sanford MD, President of the Medical Society of Pennsylvania.

Board of Medical Examiners Elections

The President advised the House that members of the Board of Medical Examiners had been elected in a general session held on Thursday, April 26, 1973, at the

Baltimore Civic Center as follows:

DeWitt E DeLawter MD, Bethesda

John E Adams MD, Baltimore

Election of Officers

There being no candidates nominated from the floor and there being only one candidate for each of the positions to be filled, by unanimous consent, the ballot was dispensed with. The following were then elected:

President-elect

Manning W Alden, Annapolis

(President-elect 1973-74)

(President 1974-75)

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J Parran Jarboe, LaPlata (1975)

Second Vice President

William G Speed III, Baltimore (1975)

Third Vice President

Robert G Angle, Bethesda (1975)

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Joseph I Berman, Baltimore (1977)

Katherine H Borkovich, Baltimore (1977)

James B Brooks, Baltimore (1977)

John R Davis Jr, Baltimore (1973-76)

Roland T Smoot, Baltimore (1977)

Eastern District

E Kent Carney, Salisbury (1977)

South Central District

Francis C Mayle Jr, Bethesda (1977)

Barry Rosenberg, Hyattsville (1977)

Merton L White, Silver Spring (1977)

Southern District

Henry L Burke III, LaPlata (1977)

Western District

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John M Dennis, Baltimore

(Jan 1, 1974 — Dec 31, 1976)

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Sheldon C Kravitz, Baltimore (1974-78)

Library and History Committee

Margaret L Sherrard, Baltimore (1974-79)

Finney Fund Committee

Richard V Hauver, Hagerstown (1974-79)

Continuing Medical Education Committee Report

Henry R Herbert MD, on behalf of the Continuing Medical Education Committee, made a verbal presentation. A copy of the printed report will be made available with the annual reports and presented at the semiannual session.

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Maryland Medical Political Action Committee Report

Raymond L Markley MD, Chairman of the Maryland Medical Political Action Committee, reported verbally to the House. A copy of his printed remarks will be made available with the annual reports and presented at the semiannual Session.

Woman's Auxiliary Report

Mrs Marvin L Kolkin, President of the Woman's Auxiliary, made a verbal report to the House. A copy of her printed remarks will be made available with the annual reports.

Maryland Foundation for Health Care Report

Manning W Alden MD, Chairman of the Board of the Maryland Foundation for Health Care, made a verbal report to the House constituting the annual meeting of the Foundation to the Administrative Members of the Foundation, which are the members of the House of Delegates. A copy of this report will be made available with the annual reports.

Reference Committee Report

Herbert H Leighton MD, on behalf of the Reference Committee, recommended that Resolution 1A/73 be amended by substitution. The proposed substitute was adopted and, as thus amended, the Resolution was adopted as follows:

Resolution 1A/73 Substitute Resolved Adopted

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland do everything in its power to effect changes in Maryland's Medicaid program to accomplish the objective that Usual, Customary, and Reasonable fees be paid under the State's Medicaid program.

Resolution 2A/73 Tabled

Dr Leighton, on behalf of the Reference Committee, moved that Resolution 2A/73 be referred to the Ad Hoc Building Committee for its information and report to the Semiannual Meeting. After debate, a motion to table the resolution which reads as follows was adopted, by a vote of 52 Ayes to 31 Nays:

WHEREAS, The majority of the members of the Medical and Chirurgical Faculty of the State of Maryland live in the vicinity of Baltimore City; and

WHEREAS, The center of medical activity in the State is the City of Baltimore where the two medical schools are located; and

WHEREAS, The Mayor of the City of Baltimore has assured the Baltimore City Medical Society that he is prepared to use necessary City resources to solve problems of parking and additional space; and

WHEREAS, The members of the Baltimore City Medical Society, at its General Meeting held Feb 1, 1973, unanimously adopted a resolution opposing the move of the headquarters and library of the Medical and Chirurgical Faculty of the State of Maryland from Baltimore City and directing that a resolution to this effect be introduced and supported by the Baltimore City Medical Society Delegates at the 175th Annual Meeting of the Medical and Chirurgical Faculty House of Delegates in April, 1973; be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland opposes the move of the headquarters and library of the Medical and Chirurgical Faculty of the State of Maryland from the City of Baltimore; and be it further,

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Resolved, That the appropriate authorities in the Medical and Chirurgical Faculty of the State of Maryland be directed to contact the Mayor of the City of Baltimore to discuss the availability of space in Baltimore City which would provide adequate office space and parking space to house the headquarters and library.

Resolution 3A/73 and Substitute Rejected

Dr Leighton, on behalf of the Reference Committee, moved that Resolution 3A/73, not be adopted; and after a substitute amendment was rejected, the resolution, which reads as follows, was rejected:

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland convey to the State Insurance Commissioner its concern over the disparity of fees paid under Blue Shield program C; as well as other programs offered by Maryland Blue Shield; throughout the State even though the premiums paid for such programs is the same throughout the State; and be it

Resolved, That the State Insurance Commissioner be requested to see that Maryland Blue Shield upgrades the fee profiles of physicians in nonmetropolitan areas to a level equal to that of metropolitan physicians; or that subscribers' premiums be adjusted to reflect the disparity in benefit payments made.

The House also rejected Resolution 3A/73, which reads as follows:

WHEREAS, Medical care throughout the State of Maryland is generally rendered by well trained physicians; and

WHEREAS, The cost of living differential in different areas of the State is essentially the same; and

WHEREAS, The cost of Maryland Blue Shield, Medicare, and other forms of insurance for the payment of physician's services is the same throughout the State of Maryland; and

WHEREAS, Labor Unions of this nation have established equal pay for equal work regulations; and

WHEREAS, The Maryland Blue Shield, Medicare, and other third-party payors continue to differentiate their reimbursement formulae on a regional basis; and

WHEREAS, Such regionalization of physician reimbursement is unfair to physicians practicing in the non-metropolitan areas of the State; be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland, on behalf of the practicing physicians of Maryland, file a class action suit against all third-party payors, especially Maryland Blue Shield and the Social Security Administration, to cause them to equalize physician reimbursement formulae so that all physicians of the State are paid a fair and equal fee for professional services.

Resolution 4A/73 Rejected

Dr Leighton, on behalf of the Reference Committee, recommended rejection of Resolution 4A/73, which after debate was NOT ADOPTED; and reads as follows:

WHEREAS, The Medical and Chirurgical Faculty of the State of Maryland is gradually increasing its services and activities to the members and to the citizens of the State of Maryland; and

WHEREAS, The office space available in the Faculty Building is congested and overcrowded; and

WHEREAS, There are no plans for expansion at this time; be it

Resolved, That the Medical and Chirurgical Faculty discontinue the rental of office space to other than

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Resolution 5A/73 and Substitute Rejected Unanimously

Dr Leighton, on behalf of the Reference Committee, recommended rejection of Resolution 5A/73, which after debate was unanimously rejected; after a substitute amendment was rejected. The Resolution reads as follows:

WHEREAS, There is great public concern over members of hospital boards being involved in a conflict of interest; and

WHEREAS, This concern is also expressed in other areas such as legislative, political and related fields; and

WHEREAS, This is a proper concern by the Faculty because individuals should not be placed in a position of having to make a choice with respect to the area in which their loyalties lie; and

WHEREAS, On occasion, despite attempts to be completely neutral, elected officials of the Faculty may be directly involved in a conflict of interest situation; and

WHEREAS, There have been some members of the Faculty who have expressed concern that their best interests and the best interests of the practicing physician community may not be represented by individuals holding elective positions in the Faculty while at the same time acting in a fiduciary capacity on policy making bodies for third-party insurance carriers or government agencies; be it

Resolved, That it be the policy of the Medical and Chirurgical Faculty of the State of Maryland that elected officials of the Faculty who act in a fiduciary capacity or in policy making decisions for third-party insurance carriers or governmental agencies exclude themselves from policy or other decisions of the Faculty whenever such a conflict of interest might arise.

Resolution 6A/73 Not Considered

Dr Levitsky, on behalf of the Prince George's County delegation, requested the House to consider Resolution 6A/73. The House refused to consider the resolution there not being two thirds in favor of doing so. The resolution reads:

WHEREAS, The Executive Committee of the Medical and Chirurgical Faculty of Maryland has adopted a statement on the role of the professional nurse at its meeting on June 1, 1972, and has defined that role as including primary, secondary, and tertiary care, and this role as being collaborative with respect to the physician; and

WHEREAS, Upon inspection of this statement it is not clear the degree of independent judgment and action allowed by that statement to the practitioner of nursing; and

WHEREAS, It is in the interest of good medical practice and the general public welfare that medical judgment be legally applied only by those licensed as practitioners of medicine, and to none other; now therefore, be it

Resolved, That the Executive Committee of the Medical and Chirurgical Faculty of Maryland review its previously published statements relating to the role of professional nursing and present to the House of Delegates a revised statement, if necessary, which clearly defines the role of a professional nurse as being at all times under the direct supervision or direct responsibility of a licensed practitioner of medicine in Maryland.

Communication From Washington County Medical Society

The President, at the request of the Washington County Medical Society, read the following resolution for information only:

WHEREAS, The Washington County Medical Society believes in the traditional concept of the private practice of medicine as opposed to the socialistic concept; and

WHEREAS, The Washington County Medical Society regards the concept of Professional Standards Review Organizations as being an intermediate step toward the full socialization of medicine in the United States and the total regimentation of the profession and the whole health care system.

Now, Therefore, the Washington County Medical Society expresses its total, absolute, and unyielding opposition to the Professional Standards Review Organizations concept. The practical application of this position being the following (incorporated in and being a part of this resolution).

A copy of this resolution shall be sent by the Secretary to the following: The Medical and Chirurgical Faculty, the AMA, and all specialty society organizations both state and national, all our elected representatives both to the General Assembly and the Congress, the President of the United States, and the Secretary of Health, Education, and Welfare.

The officers, delegates, executive committee, and all other Washington County Medical Society Representatives shall be instructed to implement the wishes of the Society in public.

A presentation in depth embodying the wishes of the Society and its reasons therefore shall be prepared by the executive committee of the Society utilizing such professional assistance as may be required in the public relations field. Such a program and statement shall be presented to the Washington County Medical Society at its meeting next after passage of the resolution.

New President

The Chair then introduced the new President who was greeted by a standing ovation.

Adjournment

The President, by general consent, declared the House adjourned, sine die at 3:50 PM.

WILLIAM A PILLSBURY MD, Secretary

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MINUTES

Semiannual Session, House of Delegates

(279th Meeting)

Medical and Chirurgical Faculty of the State of Maryland

Saturday, Sept 15, 1973

Faculty Building, 1211 Cathedral St, Baltimore Md

The 279th meeting of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 2:00 PM, on Saturday, Sept 15, 1973, at the Faculty Building, 1211 Cathedral St, Baltimore Md, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors

Manning W Alden, Council, President-elect
Aris T Allen, Second VP, Council
Sergio Alvarez-Velasco, Anne Arundel Co
William A Andersen, Baltimore Co
*Ian R Anderson, Baltimore City
Charles Bagley III, Wicomico Co
Timothy D Baker, Baltimore City
Emidio A Bianco, Baltimore City
Norman K Bohrer, Prince George's Co
Katherine H Borkovich, Balto City
M McKendree Boyer, S Alt Del AMA, Council, Past Pres
Robert vL Campbell, AMA Del, Council, Past Pres
Constantinos P Chilimindris, Baltimore City
John T Chissell, Council
*Thomas C Cimonetti, Howard Co
Joseph R Cowen, Baltimore City
Kenneth Cruze, Montgomery Co
William B Culwell, Carroll Co
Richard Y Dalrymple, Council
John R Davis, Council
Henry V Davis, Cecil Co
Melvin B Davis, Baltimore Co
John B De Hoff, Baltimore City
DeWitt E DeLawter, Council, Past Pres
Michael Dobridge, Montgomery Co
Frederick Young Donn, Montgomery Co
William Carl Ebeling, Council, President
Wolcott L Etienne, Council
John F Eyring Jr, Baltimore City
Robert W Farr, Kent Co
George G Finney Jr, Balto City
Vincent J Fiocco Jr, Carroll Co
Russell S Fisher, AMA Del, Council, Past Pres
Elliott R Fishel, Baltimore City
Harold H Gist, Washington Co
Edward G Grau, Baltimore Co
George H Greenstein, Balto City
Joseph B Gross, Baltimore City
Paul F Guerin, Council
Thomas Franklyn Herbert, Howard Co
Philip W Heuman, Council
Charles Earl Hill, Anne Arundel Co
Gunther D Hirsch, Harford Co
John H Hirschfeld, Baltimore City
*M Inayat, Baltimore City

Doctors

Alfred E Iwantsch, Baltimore Co
J Parran Jarboe, Council
Bernard S Karpers Jr, Balto City
Arthur T Keefe Jr, Council
Seruch T Kimble, Council
*Watson Kime, Baltimore City
Louis J Kolodner, Council
*Edward L J Krieg, Baltimore Co
William T Layman, Washington Co
Herbert H Leighton, Council
*Howard I Levine, Montgomery Co
Charles H Ligon, Council
Emory J Linder, Harford Co
Elmer G Linhardt, Council, Bd of Med Exam
*John T Lynn, Prince George's Co
Allan H Macht, Baltimore City
Francis C Mayle Jr, Montgomery Co
Karl F Mech, Treasurer, Council
*Leslie Miles, Allegany Co
Donald W Mintzer, Baltimore City
Marvin L Mones, Council
*Paul A Mullan, Baltimore City
Frederick E Musser, Council
Charles F O'Donnell, Past Pres, AMA Del, Council
Stephen K Padussis, Council
Hilary T O'Herlihy, Anne Arundel Co
Stephen E Phillips, Baltimore City
William A Pillsbury, Secretary, Council
Carolyn H S Pincock, First VP, Council
J Emmett Queen, Baltimore City
J Morris Reese, Past Pres, Council
William Reichel, Baltimore Co
*Jimmie Lee Rhyne, Baltimore City
James A Roberts, Montgomery Co
*J Courtland Robinson, Balto City
Donald J Roop, Council
Seymour H Rubin, Baltimore City
John F Schaefer, Past Pres, Council
J Thomas Schnebly, Montgomery Co
Edyth Hull Schoenrich, Balto City
*Carlton L Sexton, Baltimore City
George Sharpe, Montgomery Co
John O Sharrett, Council
Margaret Lee Sherrard, Baltimore Co
*Edward L Sherrer Jr, Balto City
Elizabeth B Sherrill, Baltimore Co
William G Speed III, Council
George R Spence, Montgomery Co
Raymond P Srsic, Anne Arundel Co
Osmar P Steinwald Jr, Balto City
*Oscar C Stine, Baltimore City
*Edward L Suarez-Murias, Balto City
*Richard M Susel, Baltimore City
Robert J Thomas, Council

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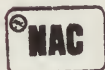
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Sidney J Venable Jr, Balto Co
Philip F Wagley, Council
Roger Gilbert Windsor, Balto Co
Henry M Wise Jr, Montgomery Co
Present also were staff personnel.

Invocation

Karl F Mech MD, Treasurer, gave the invocation.

Announcements

The President made announcements dealing with the conduct of business at the session.

Introduction Of New Members

The President introduced the following new members of the House:

Aris T Allen MD, Annapolis, Council; Second Vice President

John R Davis Jr, MD, Baltimore, Council
Herbert H Leighton MD, Oakland, Council
Charles Ligon MD, Sandy Spring, Council
Marvin L Mones MD, Silver Spring, Council
Donald J Roop, MD, Towson, Council
John O Sharrett MD, Baltimore, Council
Robert A Barnett MD, Rockville, Montgomery County

Minutes of Annual Session

The minutes of the two meetings of the House of Delegates held April 25 and April 27, 1973, having been distributed to all members and having been approved by the Executive Committee, were presented to the House for information.

Presentation of Viet Nam Plaque

Ernesto A Tolentino MD, being unable to be present at the House session, will have this plaque for voluntary service in Viet Nam mailed to him with the congratulations of the House.

Emeritus Members

On motion of the Council Chairman, Dr Speed, the following member who has received the recommendation of his component society and the Council, was elected to Emeritus Membership in the Faculty:

Prince George's County: Leonard Hays MD, Barnesville.

Endorsement of AMA Medicredit Proposal

On motion of the Council Chairman, Dr Speed, the House endorsed the AMA Medicredit proposal as it has been introduced and cosponsored by 181 members in the US Congress.

Bylaws Committee Report

John F Schaefer MD, Chairman of the Bylaws Committee, on its behalf, moved the adoption of the following Bylaw amendments, which were adopted, after debate, by more than the required two-thirds vote.

Amend the Bylaws by striking out Article XI, Section 3 and Article XI, Section 14.

Amend the Bylaws in Article XI, Section 20 last sentence by adding:

"; provided, however, that if a peer review committee of a component society fails to initiate or pursue action with respect to any complaint of an aggrieved party within 90 days of referral of the matter to it, the Peer Review Committee may take original jurisdiction of the matter."

Proposed Bylaw Change

In response to the request of the Bylaws Committee, Dr Mintzer moved the following motion which, after debate, was adopted:

That it is the sense of the House of Delegates that the Bylaws should be amended to provide that at least one sponsor of resolutions being considered appear before the Reference Committee at its hearing; or such resolution will not be considered by the House or the Reference Committee.

1972 Audit Report

Karl F Mech MD, Treasurer, presented the auditor's statement for the 1972 year. There being no objection, the auditor's statement was approved.

Information 1972 Committee Reports

The following 1972 Committee Reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions or comments.

Board of Medical Examiners—Elmer G Linhardt MD, Secretary-Treasurer

Continuing Medical Education—Gerard Church MD

Committee on Contractual Arrangements (No committee appointed 1972-1973)

Curator—Edwin David Weinberg MD

Report of the Delegates to the American Medical Association—Robert vL Campbell MD, Russell S Fisher MD, Charles F O'Donnell MD, Annual Meeting 1972, Clinical Meeting 1972

Emergency Medical Services—John B De Hoff MD

Committee on Emotional Health—Louis W Tinnin MD

Executive Director—Mr John Sargeant

Finance Committee—Karl F Mech MD

HAVES Program—Karl M Green MD, President (Hearing and Vision Early Screening Program)

Joint Practices Committee—Albert T Dawkins MD

Legislative Committee—Stephen K Padussis MD

Library and History Committee and Finney Fund Committee—Paul F Guerin MD and William H M Finney MD

Maryland Blue Shield, Board of Trustees—Charles F O'Donnell MD, Chairman

Maryland Foundation for Health Care—Manning W Alden MD

Maryland Medical Political Action Committee—Raymond L Markley MD

Medical Annals—Leslie E Daugherty MD

Medical Emergency Disaster Service Committee—(No committee appointed 1970-1971)

Maryland State Medical Journal—C Thomas Flotte MD

Commission on Medical Discipline—John M Dennis MD, Chairman

Medical Economics Committee—W Kenneth Mansfield MD

Medicine and Religion Committee—Archie R Cohen MD

Medicolegal Committee—Howard F Kinnamon MD

Med-Chi Insurance Trust—Paul F Guerin MD

Occupational and Environmental Health—Carlos Villafana MD

Peer Review Committee—Arthur E Cocco MD, Chairman
Physician/Patient Relations Committee—Louis J Kolodner MD

Committee on Preventive Medicine and Public Health—Howard J Garber MD

Committee on Program and Arrangements—Albert M Antlitz MD

Public Relations Committee—Paul A Mullan MD

Mary Louise Pierre

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Policy and Planning Committee—Arthur T Keefe Jr, MD
Professional Medical Services Committee—(No committee appointed 1972-1973)

Secretary—William A Pillsbury MD

Ad Hoc Committee on New Faculty Building—Russell S Fisher MD, Chairman

Woman's Auxiliary to the Medical and Chirurgical Faculty Report—Mrs Marvin L Kolkin

Maryland Foundation For Health Care

The following motion, offered by the Secretary, was adopted by the House, after debate:

To amend the resolution adopted by the House of Delegates on Sept 11, 1971 relating to the establishment of a Maryland Foundation for Health Care by substituting for it the following:

Resolved, That the House of Delegates approves the continued existence of the Maryland Foundation for Health Care as established under the authorization of a resolution of the House of Delegates adopted Sept 11, 1971 and approves in principle the provisions of the current Bylaws of the Maryland Foundation for Health Care provided that 1) Said Foundation shall be a functioning body of the Medical and Chirurgical Faculty of Maryland; 2) That all amendments to the current Bylaws of the Foundation be approved by the Council of the Faculty; and 3) That the Executive Director of the Faculty be the Chief Executive Officer of the Foundation.

Election, Board of Directors, Maryland Foundation For Health Care

The Secretary read a list of nominees which had been submitted for election to the Board of Directors of the Maryland Foundation for Health Care; additional nominations were made from the floor.

While nominations from the floor were being received, a point of order was made that, under Article IV, Section 2, of the Foundation's Bylaws, only component societies were entitled to make nominations. The Chair ruled that the Bylaws of the Foundation could not effectively bind the House whose rules required the Chair to accept nominations from the floor; accordingly, the Chair ruled that the Point of Order was not well taken.

Subsequently, while nominations from the floor were being received, Dr Layman moved, "That the House recess and that a meeting of the administrative members of the Foundation be convened to elect the Board of the Foundation, the House then to be reconvened."

The Chair ruled that the motion was not in order since the administrative members of the Foundation were the House of Delegates and the House could not meet except as such. From this ruling an appeal was taken by Dr Ligon and the decision of the Chair was sustained.

Those nominated for Directors of the Foundation were:

CENTRAL DISTRICT (To Elect 11)

Katherine H Borkovich—Internist	City
Douglas G Carroll—Internist	City
Marco Clayton—ENT	Harford
John M Dennis—Radiology	City
Salvatore R Donohue—Internist	City
Russell S Fisher—Forensic Path	City
Watson P Kime—Pathology	City
Edward J Kowalewski—Family Practice	City
Paul A Mullan—Pediatrician	City
Hiroshi Nakazawa—Family Practice & GS	City

Eugenie E Phillips—Ob-Gyn	City
Eugene Riley—General Surgery	Balto Co
Donald Roop—Public Health	Balto Co
Irvin Sauber—Internist	City
Alan C Woods—Surgeon	City
Sidney J Venable Jr—Family Practice	Balto Co
Roger G Windsor—Family Practice	Balto Co

EASTERN DISTRICT (To Elect 2)

Robert W Farr—Family Practice	Kent Co
Philip Insley Jr—General Surgery	Wicomico Co

SOUTH CENTRAL DISTRICT (To Elect 5)

Horace W Bernton—Internist	Montgomery Co
Louis M Damiano—ENT	Prince George's
DeWitt E DeLawter—Internist	Montgomery Co
H Herbert Insel—Ophthal	Prince George's
John T Lord—Neur Surg	Montgomery Co
George S Malouf—Ophthal	Prince George's
Joseph M O'Neil—Ob-Gyn	Montgomery Co
W Kenneth Cruze—Thoracic Surgeon	Montgomery Co
Joseph A Murgalo—Ob-Gyn	Prince George's

SOUTHERN DISTRICT (To Elect 2)

Manning W Alden—Pathologist	Anne Arundel Co
Clifford L Culp—Psychiatrist	Anne Arundel Co
Thomas F Lusby—Family Pract-Oto	Calvert Co
Lewis B Newberg—Oto	Howard Co

WESTERN DISTRICT (To Elect 2)

Harold Gist—Ob-Gyn	Washington Co
Herbert Leighton—Family Practice	Garrett Co
William Newman—Radiology	Allegany Co

After the Chair declared the nominations closed, the House, by unanimous consent, agreed to vote for the directors by ballot. The Chair appointed as tellers Drs Boyer, Jarboe, Pillsbury, and Sharrett. After members of the House had marked their ballots and the ballots had been collected, the Chair declared the polls closed.

Subsequently, the House agreed by unanimous consent, that the Tellers report be entered in the minutes although not completed until after adjournment. The Tellers report is as follows:

FOR CENTRAL DISTRICT (To Elect 11)

Number of votes cast	101
Number needed to elect	51
Dr Borkovich	received 70*
Dr Carroll	received 97*
Dr Clayton	received 82*
Dr Demuis	received 71*
Dr Donohue	received 43
Dr Fisher	received 77*
Dr Kime	received 30
Dr Kowalewski	received 93*
Dr Mullan	received 61*
Dr Nakazawa	received 60
Dr Phillips	received 87*
Dr Riley	received 88*
Dr Roop	received 86*
Dr Sauber	received 47
Dr Woods	received 88*
Dr Venable	received 14
Dr Windsor	received 7

FOR EASTERN DISTRICT (To Elect 2)

Number of votes cast	97
Number needed to elect	49
Dr Farr	received 97*
Dr Insley	received 97*

FOR SOUTH CENTRAL DISTRICT (To Elect 5)

Number of votes cast	99
Number needed to elect	50

Dr Bernton	received 48
Dr Damiano	received 57*
Dr DeLawter	received 77*
Dr Insel	received 82*
Dr Lord	received 87*
Dr Malouf	received 31
Dr O'Neil	received 86*
Dr Cruze	received 19
Dr Murgalo	received 6

FOR SOUTHERN DISTRICT (To Elect 2)

Number of votes cast	99
Number needed to elect	50
Dr Alden	received 84*
Dr Culp	received 79*
Dr Lusby	received 21
Dr Newberg	received 14

FOR WESTERN DISTRICT (To Elect 2)

Number of votes cast	100
Number needed to elect	51
Dr Gist	received 89*
Dr Leighton	received 71*
Dr Newman	received 42

The President declared that those who received the votes marked with an asterisk had been elected to the Board of the Foundation.

Ad Hoc Building Committee Report

Dr Fisher, on behalf of the Ad Hoc Building Committee, moved the following resolutions which, after debate, were adopted:

1. *Resolved*, That the Ad Hoc Building Committee is hereby authorized to negotiate the purchase of property located to the south of the present Faculty building and adjoining it, at a sum that is prudent, and that would provide for early possession. It is estimated this would be approximately \$85,000, based on previous sales in the general area. It is understood that in so negotiating, the purchase will be on the basis that the land will be cleared and present buildings razed.
2. *Resolved*, That the Ad Hoc Building Committee be authorized to have architects prepare plans for a new office building to adjoin the present Faculty building with the costs to come from present building funds.
3. *Resolved*, That the Ad Hoc Building Committee present to this House of Delegates the cost of such an addition, together with the mechanisms to be used for its financing; this report to be made at the 1974 Annual Meeting.

Reference Committee Report

Substitute Resolution 1S/73 Adopted

Melvin B Davis MD, Chairman of the Reference Committee, presented its report with respect to Resolution 1S/73 and, on behalf of the Committee, offered a substitute amendment. By unanimous consent, Dr Layman was granted leave to speak on behalf of the Washington County delegation for not to exceed 18 minutes. After further debate, on a division vote of 42 in the affirmative and 33 in the negative, the Committee substitute was adopted and, as thus amended, the substitute Resolution 1S/73 was adopted as follows:

Resolved, That while it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve the high quality of patient care in Maryland, the Medical and Chirurgical Faculty of the State of Maryland opposes any regulation that would interfere in the provision of high quality medical care;

and that would tend to increase federal control over the practice of medicine; and be it further

Resolved, That the Council of Medical and Chirurgical Faculty of the State of Maryland work actively to seek the repeal or modification of either the PSRO law or regulations relating thereto should events occur that could lead to federal control of the practice of medicine.

New Business

Resolution Commending John M Dennis MD Adopted

The following resolution was offered by Dr Bagley and unanimously adopted:

WHEREAS, John M Dennis MD, Chairman of the Department of Radiology at the University of Maryland School of Medicine, has for many years been an active and valued participant in the affairs of the Medical and Chirurgical Faculty of the State of Maryland; and

WHEREAS, He has served with distinction as the first and only Chairman of the Commission on Medical Discipline, combining leadership to the members of the Commission with tolerance and understanding toward those persons coming before it; and

WHEREAS, Dr Dennis has been appointed Acting Dean of the University of Maryland School of Medicine, necessitating his relinquishing his chairmanship of the Commission; now, be it

Resolved, That this House commends Dr Dennis for his distinguished contributions to Medical and Chirurgical affairs and to the Commission on Medical Discipline, and expresses its pleasure at his appointment as Acting Dean of the University of Maryland School of Medicine; and be it further

Resolved, That the Secretary be instructed to spread

this resolution upon the minutes of this meeting and a copy be sent to him.

Resolution on S1179 Adopted

The following resolution, introduced by the Prince George's County Delegation, after approval for consideration was granted by more than a two-thirds vote, was adopted unanimously:

WHEREAS, The Senate Finance Committee has very recently reported out a bill favorably, S1179, that reforms the provisions for private pension plans; and

WHEREAS, This bill provides for a limitation on the contributions to a retirement system of an owner-employee of a professional corporation to a maximum of \$7,500 or 15% of his income, whichever is less; and

WHEREAS, No such limitation is placed on owner-employees of large corporations; now, therefore, be it

Resolved, That this House of Delegates expresses itself as being in opposition to the discriminatory provision of the bill in respect to its limitations on contributions by owner-employees of small businesses and professional corporations; and that immediate contact be made with Maryland's Congressional Delegation as well as all members of the House Ways and Means Committee expressing its opposition to such discriminatory provisions.

Adjournment

The House, after approving the entering of the results of the election for the Board of Directors, Maryland Foundation for Health Care, in the minutes of the meeting, adjourned sine die at 4:35 PM.

WILLIAM A PILLSBURY MD, Secretary

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusion, states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-300-F (10/71)

For complete details, including dosage, please see full prescribing information.

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The Committee on Drugs of the
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The American College of Allergists

The Executive Committee of the
American College of Obstetricians
and Gynecologists

The Board of Regents of the
American College of Physicians

The Board of Trustees of the
American Dental Association

The Board of Trustees of the
American Medical Association

The American Psychiatric Association

The Executive Committee of the
National Association of Retail
Druggists

The Board of Directors of the
Pharmaceutical Manufacturers
Association

The National Wholesale Druggists'
Association



Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage inter-professional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that

economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

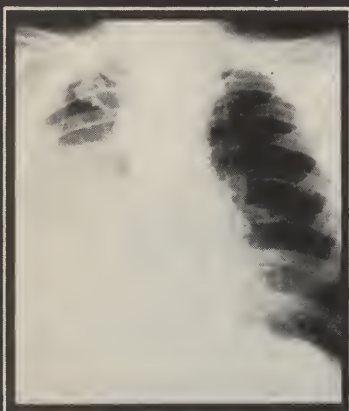
There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

*Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005*

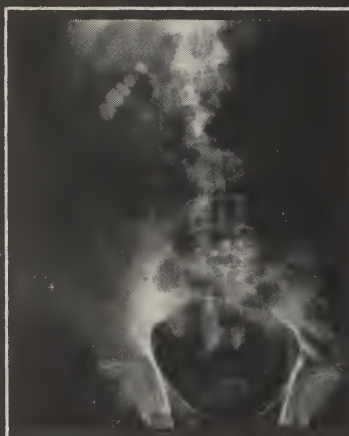


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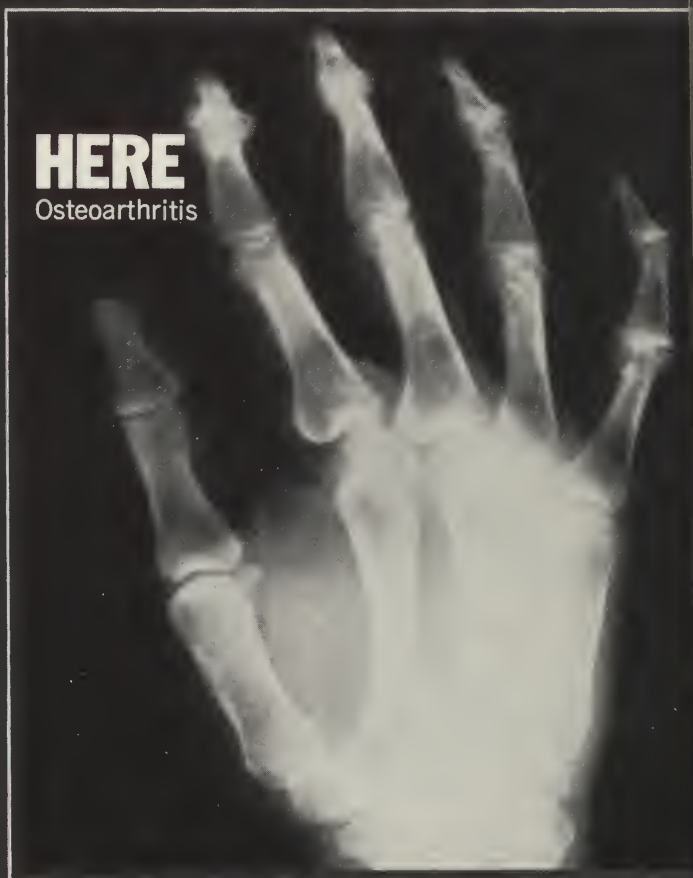
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WHEREVER IT HURTS

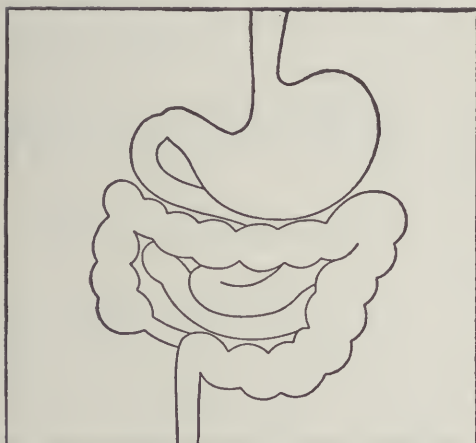
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SEMIANNUAL REPORTS TO THE HOUSE OF DELEGATES

SEPT 15, 1973

BYLAWS COMMITTEE

Mr President and Members of the House of Delegates:

The Bylaws Committee met on Thursday, July 26, 1973 to discuss various pending items. The following Bylaw changes are recommended to the House of Delegates:

1. To amend the Bylaws by striking out Article XI, Section 3.

To amend the Bylaws by striking out Article XI, Section 14.

(Subsequent sections of this Article will automatically be renumbered as a secretarial correction.)

This amendment would delete the committees indicated from the list of standing committees of the Faculty. The Contractual Arrangements Committee has not been active nor had any matters referred to it since 1967. The records reveal that prior to this time only three meetings have been held since its formation in 1966. No meeting has been held since July of 1967. Most of the meetings were devoted to a discussion of the separation of professional and technical components under Medicare.

Since the Committee has been inactive and any matters involving its charge under the Faculty Bylaws can adequately be handled by other committees of the Faculty, it is recommended that this committee be abolished.

In addition, this amendment would abolish the old Medical Emergency Disaster Services. In 1971, the House of Delegates approved formation of a new Committee on Medical Emergency Services, encompassing more than just disaster care. This new committee now includes responsibility for the previous charge of the Medical Emergency Disaster Committee and it is recommended that this committee also be abolished.

2. Amend the Bylaws in Article XI, Section 20, last sentence by adding:

"; provided however, that if a Peer Review Committee of a component society fails to initiate or pursue action with respect to any complaint of an aggrieved party within 90 days of referral of the matter to it, the Peer Review Committee may take original jurisdiction of the matter."

This amendment would permit the Peer Review Committee of the Faculty to assume jurisdiction in a peer review case if a component medical society is not actively pursuing a resolution of the matter within 90 days of its referral to that component.

It is believed this is sufficient time for a component medical society to become actively involved in resolving a peer review matter and that failure to act justifies intervention by the state Peer Review Committee. The Bylaws Committee recommends the adoption of this bylaw amendment.

3. In the Reference Committee report submitted to the House of Delegates on April 27, 1973, a suggestion was offered that a requirement be established that sponsors of Resolutions should be present at Reference Committee hearings in order for the Resolution to be considered.

Your Bylaws Committee considered this suggestion but has no specific recommendation at this time. Your Committee would appreciate some expression of sentiment from the House.

The Bylaws Committee considered other matters at this meeting and presents the following for information purposes only.

1. Considered the question of making the present Subcommittee on Alcoholism a Standing Committee of the Faculty. This was considered at the request of the Chairman of the Subcommittee on Alcoholism. The Bylaws Committee does not consider this appropriate action at this time. The newly formed Committee on Preventive Medicine and Public Health, of which this is a subcommittee, was only formed two years ago and insufficient time has elapsed to ascertain if this structure can function adequately. It is believed that the present structure can accomplish the objectives desired by this House.

2. Considered several questions regarding Peer Review as suggested by the Baltimore City Medical Society. These are:

- (a) A request that third-party carriers contact the Faculty office prior to submitting a case for peer review to ascertain the component society to which the physician belongs. The cases would then be submitted to that component society directly.

The Bylaws Committee felt this would be cumbersome and place a roadblock in the way of third parties submitting cases for review. Administrative changes were made at the time of the receipt of this letter to ensure that all cases are referred directly to components and not considered by a Faculty committee before transmittal. Faculty committees will then only be informed of the decision in the case and hear it on appeal if such is made by either party to the case.

- (b) Considered a suggestion to have included in the Faculty Bylaws "confidentiality as demonstrated by law," and also confidentiality "already noted in law." Neither the Committee members, legal counsel, nor the Parliamentarian could understand what was meant by these phrases. Baltimore City was requested to resubmit this suggestion by citing the applicable statute and to clarify what was being proposed. If this is done, the Bylaws Committee will reconsider the matter.

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3. Discussed membership categories in the Faculty Bylaws where there are differences in some component societies bylaws. The components involved have been requested to make amendments in order to bring them into line with Faculty membership categories. Article I, Section 3, applies and reads:

"Only one component society shall be chartered in any county or Baltimore City. Component societies may write their own bylaws provided they do not conflict with the requirements of the Faculty."

COMPARISON OF PROPOSED CHANGES, BY LAWS, FOR CONSIDERATION SEPT 15, 1973

OLD

Article XI, Section 3

Section 3. As soon as practicable after the annual session each year a COMMITTEE ON CONTRACTUAL ARRANGEMENTS shall be appointed whose purposes it shall be (a) to render assistance to those members who request it in clarifying the ethical standards applicable to specific contractual arrangements they have, and (b) to assist those members who request support in negotiating ethical contracts. The committee shall be appointed by the Faculty's President and be composed of a chairman and one member selected from and nominated by each of the following specialty groups: Maryland Society of Internal Medicine; Maryland Radiological Society; Maryland Chapter, American Academy of General Practice; Maryland Orthopedic Society; Maryland Pediatric Society; Maryland Ear, Nose and Throat Society; Maryland Society of Pathologists; Maryland Thoracic Surgical Society; Obstetrical and Gynecological Society of Maryland; Maryland Ophthalmological Society; Maryland Society of Anesthesiologists; Maryland Chapter, American College of Surgeons; Maryland Psychiatric Society; Maryland Dermatological Society; and Maryland Chapter, Industrial Medical Association. All members of the Committee shall be members of the Faculty. Should any specialty group fail to submit a nomination within sixty days from the date requested to do so, the President may appoint any member of the specialty group to fill the vacancy. Nine members of the committee shall constitute a quorum.

NEW

None

OLD

Article XI, Section 14

Section 14. A MEDICAL EMERGENCY DISASTER SERVICE COMMITTEE of at least five members shall develop plans for medical aid in the event of a civilian disaster or enemy attack. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.

NEW

None

OLD

Article XI, Section 20

Section 20. The President shall appoint a PEER REVIEW COMMITTEE of at least nine members, three of whom shall be appointed annually for three-year terms. It shall be the duty of this committee to advise third party and other agencies as to the appropriateness of medical care rendered by Maryland physicians in institutions

and offices or other locations where health care is rendered. It shall develop suitable criteria to adequately evaluate the individual and collective volume, cost and quality of medical care wherever provided. The Committee shall stimulate area hospitals' medical staffs to develop appropriate mechanisms such as utilization committees for review of hospital admissions with respect to need for admission, lengths of stay, discharge practices, and evaluation of services ordered and provided. The chairman shall be designated annually by the President. Any party aggrieved by the action of local Peer Review Committees may, within 30 days of such action, file an appeal in writing with the Peer Review Committee, which shall hear the appeal.

NEW

Section 20. The President shall appoint a PEER REVIEW COMMITTEE of at least nine members, three of whom shall be appointed annually for three-year terms. It shall be the duty of this committee to advise third party and other agencies as to the appropriateness of medical care rendered by Maryland physicians in institutions and offices or other locations where health care is rendered. It shall develop suitable criteria to adequately evaluate the individual and collective volume, cost and quality of medical care wherever provided. The Committee shall stimulate area hospitals' medical staffs to develop appropriate mechanisms such as utilization committees for review of hospital admissions with respect to need for admission, lengths of stay, discharge practices, and evaluation of services ordered and provided. The chairman shall be designated annually by the President. Any party aggrieved by the action of local Peer Review Committees may, within thirty days of such action, file an appeal in writing with the Peer Review Committee, which shall hear the appeal; (CAPS portion to be added.)

PROVIDED HOWEVER, THAT IF A PEER REVIEW COMMITTEE OF A COMPONENT SOCIETY FAILS TO INITIATE OR PURSUE ACTION WITH RESPECT TO ANY COMPLAINT OF AN AGGRIEVED PARTY WITHIN 90 DAYS OF REFERRAL OF THE MATTER TO IT, THE PEER REVIEW COMMITTEE MAY TAKE ORIGINAL JURISDICTION OF THE MATTER.

Respectfully submitted,

JOHN F SCHAEFER MD, Chairman

CHARLES F O'DONNELL MD

VINCENT J FIOCCO MD

J PARRAN JARBOE MD



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REFERENCE COMMITTEE

Mr President and Members of the House of Delegates:

Only one resolution was introduced for consideration of the House prior to the deadline, July 23, 1973. All Faculty members were notified of the Reference Committee meeting by postcard dated Aug 1, 1973; members of the House of Delegates and officials of component societies were also notified under date of July 31, 1973.

The Reference Committee was pleased to see a nine-man delegation from the Washington County Medical Society present to speak in support of its resolution. There were also others present from Baltimore City and Baltimore County.

Resolution 1S/73

WHEREAS, Section 249F, of HR 1, (PL 92-603) regarding PSRO (Professional Standards Review Organizations) will:

1. Interfere with the present doctor-patient relationship cherished by both parties and interpose an expensive and unnecessary federal bureaucracy between the patient and his physician; and
2. Deny the physician his right to determine when his patient needs hospital care and for what period of time he needs such care (PL 92-603, Section 1155 (2), page 105); and
3. Deny to the physician his right to establish appropriate courses of treatment which in his judgment are necessary for his patient's care; and
4. Achieve cost control by denying to the patient ready access to the health care system; and

WHEREAS, In the time remaining, it is entirely conceivable that the law will be found unconstitutional or can be repealed by concerted action on the part of organized medicine; and

WHEREAS, There are serious punitive provisions in the law (PL 92-603, Section 1160 (2) and (3), page 111); and

WHEREAS, The regulations under which the physician must operate are not as yet promulgated by the US Secretary of Health, Education, and Welfare; and

WHEREAS, If we do not participate in any way in PSRO there can be no PSRO in Maryland until 1 Jan 1976, (PL 92-603, Section 1152, C (1), page 103); therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland's official position in regard to PSRO is the following:

"Non-participation by the Faculty pending further study and evaluation of the regulations when published by the US Secretary of Health, Education, and Welfare."

The Reference Committee considered the viewpoints of those persons present. It was brought out that PSRO regions will be designated by the Secretary of Health, Education, and Welfare, effective Jan 1, 1974. Implementation of PSRO (Professional Standards Review Organizations) will occur following that date; and following receipt of requests from appropriate organizations to act in this capacity.

In effect, the implementation of this law will take place regardless of whether the Faculty, any state medical society, or any county medical society wishes to participate or not. The resolution points out, however, that if such nonparticipation occurs, implementation of the law itself cannot take place until Jan 1, 1976, at the earliest.

The Reference Committee is cognizant of the fact that some component societies are already making arrangements to approve the concept of PSRO. Others have indicated their desire to be in certain PSRO areas or regions. Still others have officially endorsed PSRO and are seeking to take an active part in this activity.

The Reference Committee recognizes that the term "nonparticipation" as spelled out in the resolution can mean anything from nonparticipation in the designation of PSRO areas or regions, which would mean that the US Department of Health, Education, and Welfare will make this determination on its own; or nonparticipation in applying for PSRO designation and thus delaying the effective date of any PSRO operation in a community until Jan 1, 1976.

The Reference Committee is of the opinion that participation or nonparticipation should be a decision reached at a local level and thus permit each component medical society to make this determination on its own. To date, only one component medical society has taken an official position of noncooperation.

The Faculty's House of Delegates, on April 27, 1973, adopted the following statement:

"Resolved, That the membership of this Society be informed that the Medical and Chirurgical Faculty has taken no official stand to date on PSRO as embodied in HR 1 (the Bennett Amendment); and

"Resolved, That in the coming months every effort of our society and its members be expended to acquaint themselves with the law and its (as yet unpublished) regulations so that an informed decision may be made at the appropriate time."

The Reference Committee, therefore, offers the following substitute Resolution 1S/73 for adoption by this House:

Resolved, That while it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve the high quality of patient care in Maryland, the Medical and Chirurgical Faculty of the State of Maryland opposes any regulation that would interfere in the provision of high-quality medical care; and that would tend to increase federal control over the practice of medicine, and be it further

Resolved, That the Council of the Medical and Chirurgical Faculty of the State of Maryland work actively to seek the repeal or modification of either the PSRO law or regulations relating thereto should events occur that could lead to federal control of the practice of medicine.

Respectfully submitted,

MELVIN B DAVIS MD, Chairman
VINCENT J FIOCCO MD
MICHAEL DOBRIDGE MD
ANDREW C MITCHELL MD
LOUIS R RANDALL MD

AD HOC BUILDING COMMITTEE

Mr President and Members of the House of Delegates:

Your Building Committee has carefully examined the space needs for the Faculty and a 25-50 year projection for these needs. This was done in the light of the needs of the Maryland Foundation for Health Care, regardless of whether the PSRO concept of the Federal Government is supported formally by the Faculty. In addition, space needs for other purposes were also considered in some depth by our group.

At the Annual Meeting in 1972, the House of Delegates authorized the purchase of land in Howard County for various possible future uses. It was suggested at that time the Faculty could build a new headquarters building in this location.

Since then, the Mayor of the City of Baltimore has extended to us assistance to ascertain if a suitable location in the City could be found. Your committee looked at many, in company with authoritative people in real estate. Either the cost was too high or the location was not suitable.

Finally, it was suggested the Faculty might wish to purchase the adjacent property located to the south of our present building, formerly School #49. It is currently scheduled for abandonment some time in 1975-1976, although this schedule can be improved upon.

After considerable thought on this matter it was deemed that this was a suitable alternative, given the facts that:

1. The moving of present Faculty tangible items of equipment, particularly the library to any new location would be extremely expensive.
2. The location in Baltimore City, one occupied since 1909 (over 64 years), is centrally located for a majority of physicians in the State. The Baltimore Metropolitan area (Baltimore City, Baltimore, Harford, and Howard counties) includes over half the Faculty membership (2,400).
3. With the advent of high-speed highways in and around Baltimore City, Faculty members coming from out of the City will find our building easier to reach than at the present time.
4. The bulk of Maryland's population is in the Baltimore Metropolitan area (State 3.9 million; Metropolitan Baltimore 2 million).
5. The only two medical schools in the state are located in close proximity to the Faculty building.
6. Removal to a location outside of the City would present an economic hardship on lower-pay employees of the Faculty. In fact, it would be most difficult to obtain custodial staff for the building, if not impossible, because of the inaccessibility of the Howard County location vis a vis most other locations.
7. The Faculty is currently renting office space for the Maryland Foundation for Health Care which also would face the same problems.

Estimates for additional Faculty space are as follows, including new items not currently provided in the present Faculty building:

1. Office space for the Maryland Foundation for Health Care—7,500 sq ft.
2. Office space for the proposed new Med-Chi Insurance Agency, which will heavily involve itself in provision of professional liability insurance to members, and probably will expand into other insurance fields. The formation of this agency will also enable more adequate and accurate service to be provided members, eg:
 - (a) Estate, retirement, and life insurance planning (currently frequently done by insurance agents whose main interest is in the sale of insurance)
 - (b) A claims prevention program devoted to reduction of professional liability incidence
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- 4. Expanded administrative space for Baltimore City Medical Society

All of the above items would be more than self-supporting, paying for the costs of Faculty building operations.

An expansion of present space is needed as follows:

- 1. More stack space for the library
- 2. More storage space for the Faculty's supplies
- 3. A completely private meeting room for confidential meetings. At present, when Council, Executive Committee, and other committees meet to discuss matters such as peer review, ethics, drug abuse by physicians, etc, no other meetings are held in the auditorium. Such a private room to seat about 50-60 persons, would enable more efficient use of the present space.
- 4. A private office for the Faculty President to utilize when he is in the building for the conduct of private matters
- 5. Office and storage space for the Faculty's Auxiliary
- 6. Expansion of present parking facilities. The present square footage at the rear of the Faculty building would be more than doubled by the provision of more footage and a one deck parking facility.

In addition, space would be provided to accommodate efficiently mechanical equipment (air conditioning, heating, etc), projection apparatus, Faculty supplies, staff lounge, additional dining facilities for committee meetings, adequate space for printing and photocopy equipment, and other such requirements.

Much of the space now used by the Faculty is unsuitable for office use, such as the fourth floor of the Faculty building and the basement area of the Faculty building. These would be used for other purposes.

Administrative staff would be able to work more efficiently if they were more closely related to one another when performing their work.

The Ad Hoc Building Committee, therefore, presents the following motions for consideration of the House, recommending their adoption:

- 1. *Resolved*, That the Ad Hoc Building Committee is hereby authorized to negotiate the purchase of property located to the south of the present Faculty building and adjoining it, at a sum that is prudent, and that would provide for early possession. It is estimated this would be approximately \$85,000, based on previous sales in the general area. It is understood that in so negotiating, the purchase will be on the basis that the land will be cleared and present buildings razed.
- 2. *Resolved*, That the Ad Hoc Building Committee be authorized to have architects prepare plans for a new office building to adjoin the present Faculty building with the costs to come from present building funds.
- 3. *Resolved*, That the Ad Hoc Building Committee present to this House of Delegates the cost of such an addition, together with the mechanisms to be used for its financing; this report to be made at the 1974 Annual Meeting.

Respectfully submitted,

RUSSELL S FISHER MD, Chairman
M McKENDREE BOYER MD
HENRY A BRIELE MD
A C DICK MD
E W DITTO Jr, MD
PAUL F GUERIN MD
JAMES R KARNS MD
WILLIAM J McCLAFFERTY MD

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DELEGATES TO THE AMA HOUSE OF DELEGATES JUNE 24-28, 1973, NEW YORK CITY

Mr President and Members of the House of Delegates:

Your three delegates and two alternate delegates attended the Annual Meeting of the American Medical Association House of Delegates held in New York City, June 24-28, 1973. The following is a report of the activities of the House at that session:

Russell S Fisher MD, a delegate to the AMA House, was elected to the AMA Council on Medical Education in a campaign actively supported and developed by your delegation. Four candidates were seeking this post, three having been named by the AMA Board of Trustees and one nominated from the floor.

As has been the custom in the past, your delegates, as well as staff members, were assigned to various reference committees to hear the discussion on reports and resolutions referred to these committees. Two of your delegates were active members of Reference Committees: Robert vanL Campbell MD and Charles F O'Donnell MD.

Each of three mornings during the session, the entire delegation met for breakfast to discuss major issues of importance both in voting and in decisions to be made by the House. It is believed this provides an effective mechanism for the purpose of communicating with the entire delegation as well as becoming informed on each issue raised in a report or resolution.

Summary of House Actions

Because of the wide-ranging nature of the actions taken by the House of Delegates, and for the sake of clarity, this summary will be divided into five subject areas with appropriate sub-headings: Physicians and the Government, Physicians and Hospitals and Medical Schools, Physicians and the Public, Association and Internal Matters of the House, and Miscellaneous. (Note: The items mentioned under each subject area are not all-inclusive, but include only the more significant actions taken.)

Physicians and the Government

PSROs: Two reports from the Board of Trustees outlining successful AMA efforts in providing physician input into the drawing up of PSRO regulations by the government, and in other areas, were filed by the House. In addition, two resolutions bearing on PSROs were adopted. One resolution, initiated by California and amended, reads as follows:

Resolved, That the Secretary of Health, Education, and Welfare be informed that the only organization which can give qualified peer review for physicians services to the patient, physician, government, and taxpayer are

those composed of practicing physicians, whether these are state or local groups; and be it further

Resolved, That since many of these practicing physician groups are functioning successfully, with multiple approaches, as peer review organizations, the regulations be so written to authorize these existing peer groups to continue their review as PSROs or as functioning units of PSROs, thus partially alleviating the unnecessary and costly implementation of new agencies as PSROs.

The second resolution adopted was a substitute in response to a number of resolutions introduced, ranging from those calling for the AMA to go on record in opposition to PSROs, to one urging the Association to seek repeal of the law. The substitute resolution, which conforms to PSRO policy approved by the House at the 1972 Convention, reads:

Resolved, That although it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve high quality of patient care, the American Medical Association should oppose any facets of this current legislation which act to the deterioration of quality care, publicize such deleterious facets, and place highest priority on developing and pursuing appropriate amendments to preserve high quality of patient care.

Wage-Price Controls: Six resolutions were introduced protesting discrimination against physicians under the government's Economic Stabilization Program. The Reference Committee F pointed out that, "Although Phase 3 has officially ended, discrimination . . . has not been corrected and there is no assurance that other discrimination will not arise in the future."

Accordingly, the following substitute resolution was adopted by the House:

Resolved, That the American Medical Association continue to work by all lawful and practicable means to assure nondiscriminatory treatment for physicians under present and future Economic Stabilization Programs.

FDA Drug Regulations: Six resolutions were introduced pertaining to FDA policies and regulations affecting the practice of medicine. The House adopted a substitute resolution which directs the AMA to 1) continue to protest proposed and current regulatory activities of the FDA which have the effect of restricting use of prescription drug to "official labeling"; 2) study the possibility of proposing modifications to the Food, Drug and Cosmetic Act to correct current problems; 3) continue to work closely with the FDA in the development of effective methods for evaluating drugs used primarily to alleviate subjective symptoms, or drugs for which controlled clinical studies seem inappropriate; and, 4) in continuing to work closely with the FDA, make efforts to develop an effective sys-



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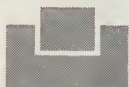
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tem of communicating the views of practicing physicians and medical specialty societies when action is proposed that may result in removal of frequently prescribed drugs from the market.

In other actions affecting the relationship of physicians with government (and third parties), the House:

- Encouraged continued efforts to develop a uniform claim form for insurance claims.
- Supported the ongoing efforts to educate physicians, private insurance plans, and government agencies as to the advantages of adopting the 3rd edition of Current Procedural Terminology to identify and report services provided by physicians.
- Directed the Council on Medical Service to study the problems presented by "prospective admission" of hospital patients under Medicare and Medicaid, "retrospective denial" of benefits, and report its findings and recommendations at the 1973 Clinical Meeting at Anaheim Calif.

Physicians, Hospitals, Medical Schools

Institutional Licensure: The House adopted Report H of the Board which calls for the AMA to oppose the extension of institutional licensure in lieu of individual professional licensure to physicians and nurses. Testimony before Reference Committee D, including representatives of the nursing profession, was unanimously in support of opposition to institutional licensure.

Quality Assurance Program: The Quality Assurance Program (peer review of hospital care and utilization) of the American Hospital Association engendered considerable discussion. Resolution 50 called for the AMA to express its reservations about the potential of QAP to bring lay control of peer review. The House adopted Report H of the Board of Trustees which discusses the reservations, recommends that AMA representatives meet with the AHA to offer its suggestions on the program, and recommends preliminary testing of QAP in a limited number of hospitals. It is emphasized that, "This report is informational and does not imply endorsement of the Quality Assurance Program by the AMA."

Support for Medical Staffs: Lengthy debate centered on Resolution 104 from Illinois which protests unilateral changes in medical staff bylaws by hospital boards of trustees that usurp the prerogatives of hospital medical staffs. Similar situations were reported in Arizona and South Dakota. A motion from the floor to refer the resolution was defeated. After considerable discussion, delegates approved the following substitute resolution:

Resolved, That the American Medical Association declares that any proposal or arrangement between a hospital board of trustees and its medical staff that conflicts with the AMA principles of medical ethics is improper; and be it further

Resolved, That unilateral changes in medical staff bylaws by hospital boards of trustees is also improper; and be it further

Resolved, That the AMA suggest that the following preamble be included in all medical staff bylaws:

The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the high quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgment and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff.

Physicians on Hospital Boards: The House also approved a substitute resolution calling for 1) increased medical staff representation on hospital boards; 2) state and local medical society efforts to remove barriers to such representation; and 3) that the Joint Commission on Accreditation of Hospitals ascertain from its inspectors the effectiveness of communications between hospital governing boards and medical staffs.

Certificate of Need Law: Report C of the Council on Medical Service and Resolution 73 (Florida) deal with mandatory Certificate of Need Laws at the state level which regulate planning for health facilities and personnel. The House adopted a substitute resolution which calls for 1) continued AMA support for voluntary planning that preserves decision-making at the local level; 2) that state certificate of need laws, if enacted, rest final authority within a board which includes representation by physicians in the active practice of medicine; and 3) that these recommendations be forwarded to the Secretary of Health, Education, and Welfare with the request that they be included in regulations for implementation of the Comprehensive Health Planning Act.

Family Medicine: Resolution 163, which emphasizes the need to increase the opportunities for medical students to obtain exposure to family medicine, was approved and referred to the Council on Medical Education.

Physician Distribution by Specialties: The House approved Report Z of the Board of Trustees which has important implications for the medical profession and for the public. The report outlines the increase in number of medical schools, the increase in approved residencies and internships, and the increased number of allied health and continuing medical education programs. The report, as amended by the House, also contains two important recommendations. They are:

AMA should adopt immediately, publicize widely, and promote vigorously a goal to have at least 50% of all medical graduates enter residency training in the primary care specialties in the coming years.

The need for numbers and type of physicians should be monitored continuously and reassessed periodically in regular reports to the House of Delegates.

Physicians and the Public

In addition to efforts to increase the number of physicians in family practice and other primary care specialties, the House also acted on several other measures aimed at improving health care for the public.

Emergency Telephone Number: Resolution 145, introduced by the Texas Delegation, highlights the importance to the public of a universal emergency telephone number for obtaining emergency care and directs the AMA to support and collaborate in current efforts to set up #911 as the nationwide emergency telephone number. A motion from the floor to refer the resolution was defeated, and the House adopted the Texas resolution.

Temporary Licensure for Physicians in Medically-Deprived Areas: The House adopted Report I of the Board of Trustees which encourages state medical societies to support amendments to the medical licensure laws to permit out-of-state physicians to practice temporarily in areas of medical need. The report also encourages state medical licensing authorities to take similar action to permit temporary licensure for physicians voluntarily serving in medical shortage areas under the National Health Service Corps or the AMA-sponsored Project USA.

Health Care for Migrant Workers: Resolution 97 (Illinois) urges that funding for improved migrant health care be obtained from a national source, and that a program for the special training of migrant health care vol-

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unteers be developed by the AMA through the Council on Medical Service and its Committee on Health Care of the Poor. The House referred the resolution to the Council with instructions to report back at the 1973 Clinical Meeting on the feasibility, plans and cost of such a program.

In other actions affecting public health care, the House:

- Adopted a resolution urging the AMA to reaffirm and support limits on air pollution levels and time schedules for conformance to the Clean Air Act of 1970.
- Urged improved liaison by the National Health Service Corps with local medical societies in areas where physicians are assigned, and pledged the continued cooperation and support of organized medicine for the program.

Association and Internal Matters of the House

Delegates acted on several important proposals aimed at protecting the interest of the practicing physician, strengthening membership, improving the response of the Association to the constituency, and making the Association more responsive to the needs of members.

The proposals ranged from AMA policy on unionism and malpractice to changes in dues requirements, terms of office of members of the Board of Trustees, and separation of the business meetings of the House of Delegates and scientific sessions.

Unions: The House adopted Resolution 86 (New York) which reaffirms the tradition of the medical profession of not withholding medical services (withholding services is a practice of most unions), or performing any act interfering with public welfare. The House also approved Report F of the Board of Trustees which opposes unionism among self-employed physicians. The report also recognizes that physicians in employment situations need assistance and support, and encourages the Board of Trustees to maintain its interest and concern for these physicians. The report also affirms the principle of no withholding of services.

Malpractice: The House took several actions in regard to medical malpractice, including approval of Report GG of the Board of Trustees which outlines the proposed formation of a Medical Liability Commission to represent health care providers in dealing with medical malpractice problems. The proposed commission was outlined on June 20 by a planning committee consisting of representatives of the AMA, AHA, American College of Surgeons, American College of Physicians, and four specialty societies. An organizing meeting for the proposed commission will be held in Chicago in September. The House also adopted a resolution commending Dr Charles A Hoffman, AMA President, for his service on HEW Commission on Medical Malpractice, and recommending wide dissemination of Dr Hoffman's dissenting report.

Intern-Resident Membership on Councils: After considerable discussion, delegates adopted Report A of the Council on Constitution and Bylaws which will change the bylaws to provide a seat on the Council on Medical Service and the Council on Medical Education for a representative for resident-intern members of the AMA. Debate centered not on the desirability of adding intern-resident representatives, but on the wisdom of mandating a seat for any particular medical group. The House acted favorably after a plea from Dr Eugene S Ograd, resident-intern delegate, that adoption was needed to further promote resident-intern membership in the AMA. In a related development, the House also approved Report BB of the Board of Trustees for the establishment of a Committee on House Staff Affairs. The committee is intended to strengthen intern and resident participation in organized medicine, and advise the Board of matters of special concern to house officers.

Separation of Business, Scientific Meetings: The House took a compromise position on Report E of the Council on Long-range Planning and Development which called for, among other things, separation of House of Delegates' meetings and Scientific meetings; holding all meetings of the House in Chicago; and the selection of widely separated locations for scientific meetings. The House adopted Reference Committee F recommendations that a meeting of the Scientific Assembly be held each year in conjunction with the Annual Convention, but that one or more additional meetings of the Scientific Assembly be held each year at times and places selected by the Board of Trustees on recommendations from the Council on Scientific Assembly. Such meetings might . . . or might not . . . conjoin with the Clinical Meeting of the House. The proposal that all House sessions be held in Chicago was rejected, and existing meetings of the House and Scientific Assembly scheduled through 1976 will not be changed.

Election and Terms of Service of Trustees: The House rejected proposals that election of trustees be on a geographic or regional basis, concurring with the Reference Committee on Constitution and Bylaws that the present system has achieved a fair degree of regional representation. Rather than adopt a proposal that recommended retention of three-year terms for trustees for a maximum of three years, the House instructed the Council on Constitution and Bylaws to prepare for the 1973 Clinical Meeting a measure that will allow the House to vote on whether trustees shall serve a maximum of two three-year terms.

Membership Certification and Dues: The House adopted several recommendations in these two areas, including:

Physicians shall become members of the AMA upon certification by state medical societies rather than by AMA receipt of dues.

The delinquency date for remittance of AMA dues is

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changed from June 1 to April 30 of each year, and the requirement that members who have been dropped for nonpayment of dues must pay one year's past dues is eliminated.

The criteria for exemption from AMA dues shall be consistent with exemption from state medical society dues, except that members reaching their 70th birthday may apply directly to the AMA for Active Dues Exempt Membership status.

Elimination of the requirement that AMA membership be limited to those physicians in military service whose tour of duty is two years or more. Younger physicians serving two years or less in the military or the US Public Health Service will be eligible for AMA membership, and county and state medical societies are encouraged to adopt this procedure.

Formal Planning System for the AMA: Delegates approved Report D of the Board of Trustees which details a comprehensive, formal, long-range planning system for the AMA designed by Batelle Laboratories, Columbus Ohio. The plan will improve the AMA's ability to sense change, sharpen objectives, allocate resources, measure progress, and improve communications between the AMA and constituent societies and membership.

Acting on other Association and internal matters of the House, delegates:

- Recommended that results of the second major membership poll be circularized and publicized by all feasible mechanisms.
- Rejected a resolution recommending low fat diets for meals at AMA meetings.
- Rejected a resolution calling for AMA support to limit distribution of drug samples to those requested by physicians, and to totally ban distribution of drugs with abuse potential.

Miscellaneous Actions of the House

The House commended Dr Ernest B Howard, AMA Executive Vice President, and AMA employees for their efforts during the past year. Reference Committee H described Dr Howard's progress report as a "panorama of some of the exciting programs carried out at AMA headquarters."

Bob Hope, who received the AMA Citation of a Layman Award for his philanthropy on behalf of medical facilities and causes across the country, entertained delegates with his unique comedy during the award presentation on Sunday, June 24. (Sample: Commenting on a series of bad investments he has made lately, he said that he bet against Secretariat, bought a condominium in Belfast and opened a delicatessen in Cairo).

Dr Lawrence L Weed, Professor of Medicine and Community Medicine at the University of Vermont, received the \$5,000 Brookdale Award in Medicine. Dr Weed was honored for development and implementation of the problem-oriented patient record system.

Dr William B Castle, internationally-known hematologist from Boston, received the sixth annual Dr Rodman E Sheen and Thomas G Sheen Award. He received a plaque and a \$10,000 cash prize.

In other actions, the House:

- Adopted a substitute resolution recommending that the AMA urge the enforcement of strict penalties for the use of firearms in the commission of a crime.
- Tabled a resolution urging AMA support for the open sale of condoms to minors.
- Referred to the Council on Mental Health a resolution

urging AMA support of a model penal code decriminalizing sexual behavior between consenting adults, and AMA support to end legal and employment discrimination against homosexuals. The Council was instructed to report back at the 1973 Clinical Meeting.

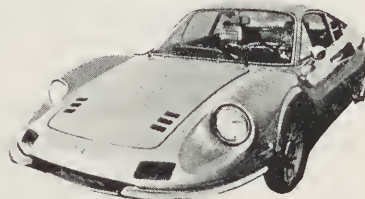
- Affirmed the traditional favorable attitude of the medical profession toward pregnancy and motherhood, and encouraged the development of counseling programs that will offer constructive help to prospective mothers in coping with the stresses of pregnancy.

- Reaffirmed the AMA abortion policy which states: "Abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in accredited hospitals acting only after consultation with two other physicians, and in conformance with standards of good medical practice and the Medical Practice Act of his state. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of good medical judgment, or personally held moral principles."

Respectfully submitted,

ROBERT F V L CAMPBELL MD, Hagerstown
RUSSELL S FISHER MD, Baltimore
CHARLES F O'DONNELL MD, Towson
Delegates
M MCKENDREE BOYER MD, Damascus
WM CARL EBELING MD, Towson
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SCIENTIFIC EXHIBITS

Scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians and medical institutions who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held at the Baltimore Civic Center on

APRIL 17, 18, 19, 1974

Ample space is available; however, it is suggested that applications be submitted as soon as possible.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
 Medical and Chirurgical Faculty
 1211 Cathedral St, Baltimore Md 21201

1. Title of exhibit:
2. Please attach a 50-100 word description of the exhibit:
3. Give amount of space required, depth, width, and height:
 If exhibit has side panels, are depth and width included above?
 If not, what additional space is required?
4. Electrical or other requirements:
5. Has exhibit been shown at other medical meetings?
6. Name and title of exhibitor:
7. Name of institution cooperating in the exhibit:
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2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide a backdrop and side rails for the booth, 500-watt electric current outlets, one covered table, & two chairs.
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5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed ONE inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

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176TH ANNUAL MEETING
MEDICAL AND CHIRURGICAL FACULTY
APRIL 17, 18, 19, 1974
BALTIMORE CIVIC CENTER**

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 3. Electrical or other requirements:
 4. Name of exhibitor:
Please print
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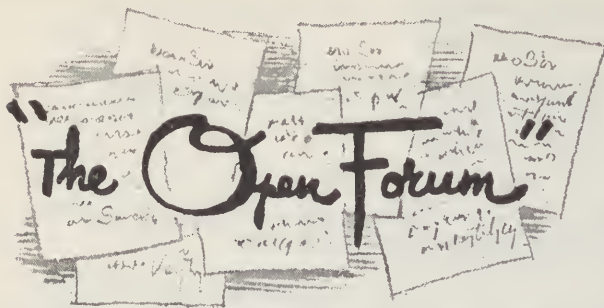
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Med-Chi members are invited to write to the editor expressing their opinions or giving information on matters of mutual interest. The Editorial Board reserves the right to select or reject communications. As with other material, all correspondence will be subject to the usual editing and possible abridgement. Material should be typewritten, double spaced, of reasonable length, and not over two pages. Address: The Editor, MARYLAND STATE MEDICAL JOURNAL, 1211 Cathedral St, Baltimore, Md 21201.

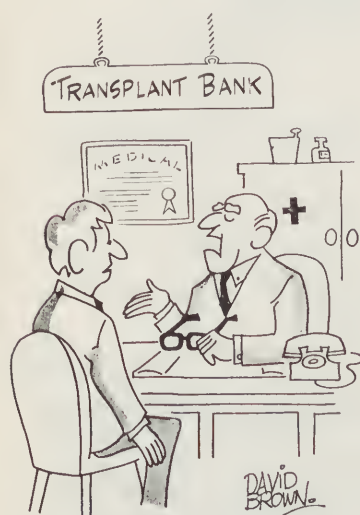
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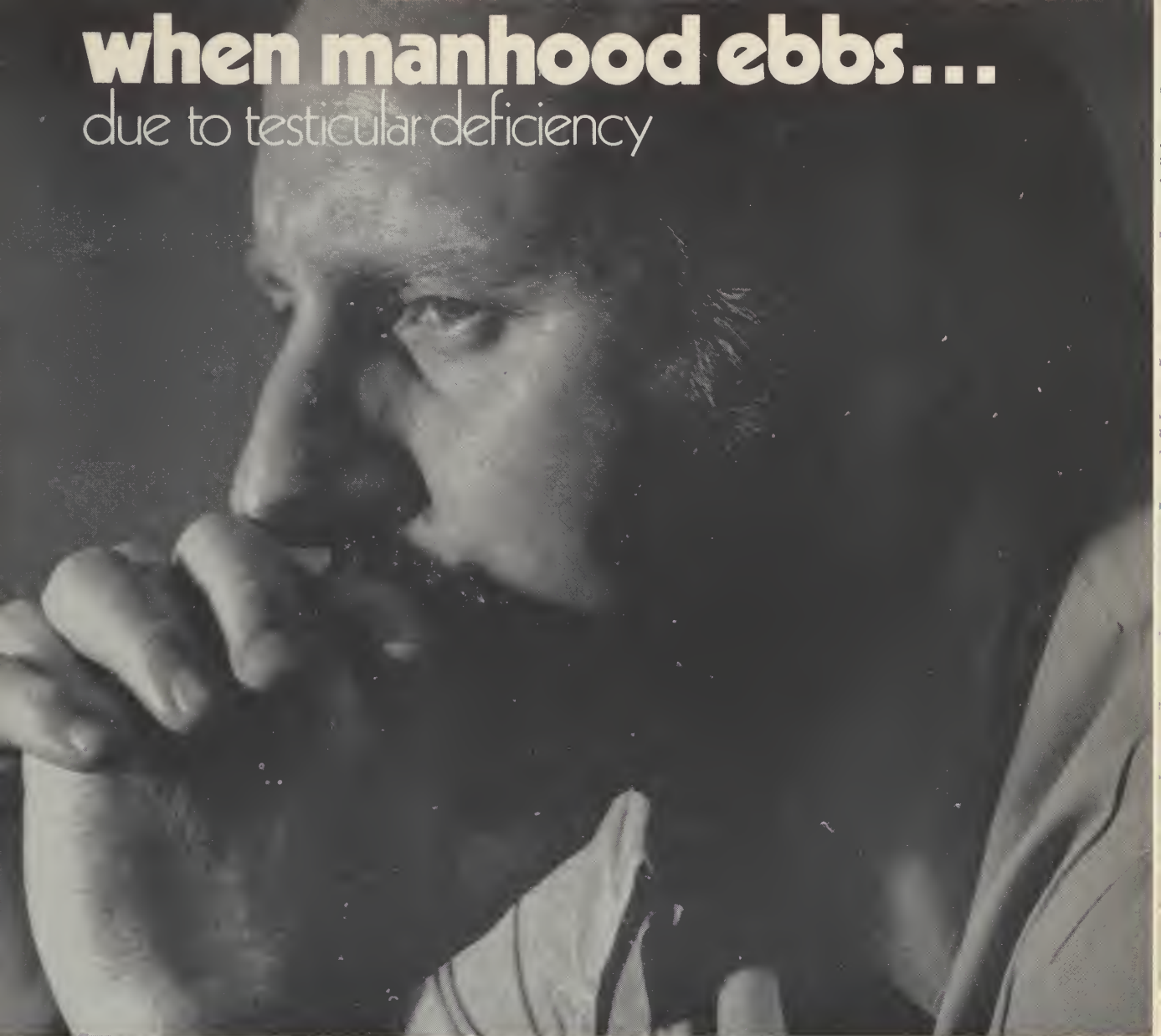
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3. Anavar Anavac Antepar
4. Arfonad Afrin Aspirin
5. Asminyl Asmolin Esimil
6. Benadryl	..... Benylin	..... Bentyt
7. Butisol	..... Butibel	..... Butabell
8. Capla	..... Keflin	..... Keflex
9. Chlorambucil	..... Chloromycetin	..... Chlor-Trimeton
10. Coramine	..... Calamine	..... Calomel
11. Cordex	..... Cordran	..... Codeine
12. Demerol	..... Dicumarol	..... Deprol
13. Digoxin	..... Digitoxin	..... Desoxyn
14. Dilantin	..... Phelantin	..... Delalutin
15. Disipal	..... Disophrol	..... Stilphostrol
16. Donnatal	..... Dianabol	..... Donnagel
17. Dopar	..... Dopram	..... Dorana
18. Doriden	..... Loridine	..... Doxidan
19. Elavil	..... Aldoril	..... Mellaril
20. Empirin	..... Empiral	..... Emprazil
21. Enduron	..... Imuran	..... Eutron
22. Esimil	..... Estinyl	..... Ismelin
23. Estomul	..... Ilomel	..... Isomel
24. Ethamide	..... Ethionamide	..... Ethinamate
25. Feosol	..... Feostat	..... Festal
26. Haldrone	..... Halodrin	..... Haldol
27. Harmonyl	..... Hormonin	..... Homapin
28. Isordil	..... Isuprel	..... Isomel
29. Kaomin	..... Kao-Con	..... Kaon
30. Kelex	..... Keflex	..... Keflin
31. Maalox	..... Maolate	..... Marax
32. Mebaral	..... Mellaril	..... Medrol
33. Meproamate	..... Meperidine	..... Mepergan
34. Mesantoin	..... Mestinon	..... Metatensin
35. Modane	..... Matulane	..... Mudrane
36. Ornex Orinase Ornade
37. Pantopon Protopam Parafon
38. Pathocil Pathilon Pitocin
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43. Tamaril Demerol Tepanil
44. Thyral Thyrolar Tryptar
45. Urised Urestrin Uracel
46. Uritol Uritral Uritone
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Indications in the male: Primary indication in the male is replacement therapy. Prevents the development of atrophic changes in the accessory male sex organs following castration: 1. Primary eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Those symptoms of panhypopituitarism related to hypogonadism. 4. Impotence due to androgen deficiency. 5. Delayed puberty, provided it has been definitely established as such, and it is not just a familial trait.

In the female: 1. Prevention of postpartum breast manifestations of pain and engorgement. 2. Palliation of androgen-responsive

advanced, inoperable female breast cancer in women who are more than 1, but less than 5 years post-menopausal or who have been proven to have a hormone-dependent tumor, as shown by previous beneficial response to castration.

Contraindications: Carcinoma of the male breast. Carcinoma, known or suspected, of the prostate. Cardiac, hepatic or renal decompensation. Hypercalcemia. Liver function impairment. Prepubertal males. Pregnancy.

Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced

ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.

Adverse Reactions: Acne. Decreased ejaculatory volume. Gynecomastia. Edema. Hypersensitivity, including skin manifestations or anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients or those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.

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For additional product information, see your Upjohn representative or consult the package circular.

*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. Beeson, P. B. and McDermott, W. eds. Philadelphia: W. B. Saunders Co., 1971, p. 1816.

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PHYSICIAN'S HANDBOOK, 17th edition, by Marcus A Krupp MD, Norman J Sweet MD, Ernest Jawetz MD, Edward G Biglieri MD, and Robert L Roe MD; Lange Medical Publications, Los Altos Calif, 1973.

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library

Proper Library Use

As the Christmas season approaches, it seems difficult to concentrate on professional matters entirely, but people still get sick, doctors still have to attend them, and the medical libraries still need to stand by to offer assistance in locating information relating to any problems that arise.

The Medical and Chirurgical Faculty Library makes an all-out effort to give its borrowers as prompt and efficient service as possible with a limited staff. In return, it helps us if you, the physicians, will give us written requests for the materials you need in as specific terminology as possible. In the case of interlibrary loans through your hospital libraries, please have the librarian indicate whether you are a Med-Chi member or not. This sometimes makes a difference in photocopying charges and also indicates to the library and Med-Chi's administration the identification of our users. This is also important when requesting bibliographic searches through MEDLINE since National Library of Medicine wants to know how many requesters are affiliates and how many are nonaffiliates.

There have been requests for many interesting subjects in this activity, such as Electrocardiography of baboons; Sexual development in the quadriplegic and paraplegic; Socio-religious aspects of dialysis and renal transplantation; Levels of health care for the mentally retarded, especially those in institutions; Child abuse; HMOs and regional health insurance programs; Toxicity from corn and soy beans; and Ischemia and muscle atrophy.

The technique for formulating bibliographic searches involves much more than the requester usually anticipates since the MEDLINE vocabulary is scientifically constructed so that the analyst must build the request in language the computer understands. This accounts for the

three-week's training course for orientation of analysts who operate MEDLINE centers as well as the follow-up workshops to study updated and new terminology. These programs are arranged and conducted at the National Library of Medicine in Bethesda.

Maryland Association of Health Sciences Librarians

At its September luncheon meeting in Annapolis at the Anne Arundel General Hospital, the Baltimore Hospital Librarians Association voted to change the name to Maryland Association of Health Sciences Librarians. Since the group has expanded to include all medical librarians in Maryland who are interested, this new phraseology will consolidate the groups.

Meetings scheduled for this association follow:

Jan 8—Md-Del-Va-DC Hospital Association. Washington Hilton Hotel. Region IV Medical Library, Grantsmanship and audiovisual tools.

Jan 17—Sheppard and Enoch Pratt Hospital. Bibliotherapy in a psychiatric hospital.

March 21—Medical and Chirurgical Faculty of Maryland MEDLINE—what it can do for your library.

May 16—Franklin Square Hospital. Computerization of hospital library holdings.

Any librarian interested in joining this association should contact the Membership Chairman, Mrs Anne Ralston, Chief Librarian, Veterans Administration, 3900 Loch Raven Blvd, Baltimore Md 21218, tel: 467-9932, X-340, 341, or the President, Mrs Elizabeth Streett, Librarian, Union Memorial Hospital School of Nursing, 3301 N Calvert St, Baltimore Md. 21218, tel: 235-7200, X-488.

NEW ACCESSIONS — BOOKS

(Arranged by Subjects)

ALLERGY

- WD McKusick, Victor A
375 **Heritable disorders of connective tissue**, 4th ed.
.M3 St Louis, Mosby, 1972

ANATOMY

- QS Crelin, Edmund S
4 **Functional anatomy of the newborn**. New
.C9 Haven, Yale Univ Press, 1973

BIOCHEMISTRY

- QU **Handbook of antimicrobial therapy**. New Ro-
250 chelle NY, The Medical Letter 1972
.H2
QU Haschemeyer, Rudy Harm
55 **Proteins: a guide to study by physical and**
.H3 **chemical methods**. New York, Wiley, 1973

CARDIOVASCULAR SYSTEM

- WG Corday, Eliot
300 **Myocardial infarction: new perspectives in diag-**
.C7 **nosis and management**. Baltimore, Williams
& Wilkins, 1973

DENTISTRY

- WU National Center for Health Statistics.
40 **Dental visits, volume and interval since last**
.N2 **visit, United States — 1969**. Rockville Md,
US Govt Print Off, 1972
WU National Center for Health Statistics.
30 **Periodontal disease and oral hygiene among**
.N3 **children, United States**. Rockville Md, US
Govt Print Off, 1972

EUGENICS

- HQ Ingle, Dwight Joyce
751 **Who should have children? An environmental**
.I6 **and genetic approach**. Indianapolis, Bobbs-
Merrill, 1973

GYNECOLOGY

- WP Cohen, S Joel
468 **The role of the operating nursing sister**. (In-
.C6 **serted at end of Cohen, S Joel, Abdominal**
and vaginal hysterectomy. Philadelphia, Lip-
pincott, 1972

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HEMIC & LYMPHATIC SYSTEM

- WH Hackett, Earle
100 **Blood**. New York, Saturday Review Press,
.H1 1973
WH International Conference on Red Cell Metabo-
190 **lism and Function**, 2d, Univ of Michigan,
1972
.I6 **Hemoglobin and red cell structure and func-**
tion; proceedings. New York, Plenum Press,
1972
WH Woodliff, H Jackson
250 **Leukemia Cytogenetics**. Chicago, Year book
.W8 Medical Publishers, 1971

HOSPITALS

- WX American Hospital Association
185 **Safety guide for health care institutions**. Chi-
.A5 cago, 1972
WX Springer, Eric W
173 **Automated medical records and the law**. Pitts-
.S7 burgh, Health Law Center, 1971

IMMUNOLOGY

- REF. Herbert, W J
QW **A dictionary of immunology**. Oxford, Black-
15 well Scientific Pub, 1971
.H5
QW Nickerson, John T
85 **Microbiology of foods and food processing**.
.N5 New York, American Elsevier Pub Co, 1972
QW Zmijewski, Chester M
570 **Immunohematology**, 2d ed. New York, Apple-
.Z8 ton-Century-Crofts, 1972

INFECTIOUS DISEASES

- WC Burnet, Frank Macfarlane
100 **Natural history of infectious disease**, 4th ed.
.B9 Cambridge, University Press, 1972
WC Felsenfeld, Oscar
410 **Borrelia; strains, vectors, human and animal**
.F3 **borreliosis**. St Louis, W H Green, 1971

MEDICAL PROFESSION

- ZW Farberow, Norman L
864 **Bibliography on suicide and suicide prevention**,
.F3 **1897-1957, 1958-1970**. Rockville Md, Na-
tional Institute of Mental Health, 1972
REF. **Foreign medical school catalogue**, 1974-
W Bay Shore NY, Foreign Medical School Infor-
19.5 mation Center
.MF7
.F7

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REF. Maryland. Department of Health and Mental
W Hygiene. Regulations. Baltimore. 1973-

33
.AM3
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REF. Medicare and Medicaid Guide. Chicago, Com-
W merce Clearing House Inc, 197(?)

275
.AA1
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W Morris, R Crawford
44 Doctor and patient and the law, 5th ed. St
.M8 Louis, Mosby, 1971

QH Ramsey, Paul
431 Fabricated man: the ethics of genetic control.
.R1 New Haven, Yale Univ Press, 1970

W Smith, Genevieve Love
15 Quick medical terminology. New York, Wiley,
.S6 1972

MEDICINE

WB Di Cyan, Erwin
120 Without prescription; a guide to the selection
.D5 and use of medicines you can get over the
counter without prescription, for safe self-
medication. New York, Simon & Schuster,
1972

WB Kleid, Jack J
100 Handbook of medical emergencies; a guide for
.K6 emergencies in internal medicine. Flushing
NY, Medical Exam Pub Co, 1970

REF. Modern drug encyclopedia and therapeutic in-
WB dex; a compendium, 12th ed. New York,
330 1973
.M6

WB The scientific basis of medicine; annual reviews.
100 1971. London, Athlone Press
.S3

WB Tan, Leong T
369 Acupuncture therapy; current Chinese prac-
.T1 tice. Philadelphia, Temple Univ Press, 1973

MUSCULOSKELETAL SYSTEM

WE Cervical pain; proceedings of the international
725 symposium held in Wenner-Gren Center,
.C2 Stockholm, January 25-27, 1971. Oxford,
New York, Pergamon Press, 1972

WE Conservative vs surgical management of foot
880 disorders. Mt Kisco NY, Futura Pub Co,
.C7 1972

WE Giannestras, Nicholas J
880 Foot disorders: medical and surgical manage-
.G4 ment, 2d ed. Philadelphia, Lea & Febiger,
1973

NURSING

WY Orlando, Ida Jean
87 The discipline and teaching of nursing process.
.O7 New York, Putnam, 1972

WY Springer, Eric W
32 Nursing and the law. Pittsburgh, Health Law
.AA1 Center, 1970

OBSTETRICS

WQ Goodlin, Robert C
16 Handbook of obstetrical and gynecological
.G6 data. Los Altos Calif, Geron-X, 1972

HQ Sarvis, Betty
767 The abortion controversy. New York, Colum-
.S2 bia Union Press, 1973

WQ Schaefer, George
150 The expectant father, rev ed, New York, Barnes
.S2 & Noble, 1972

OPHTHALMOLOGY

WW National Center for Health Statistics. Division
23 of Health Resources Statistics.

.N2 Opticians employed in health services, United
States, 1969. Washington, US Govt Print Off,
1972

PATHOLOGY

QY Early disease detection. Miami Fla, Halos,
40 Medical Book Division, 1971

.E1

REF. Garb, Solomon
QY Laboratory tests in common use, 5th ed. New
25 York, Springer Pub Co, 1971
.G2

QZ International Union Against Cancer. Commit-
200 tee on Professional Education.

.I6 Clinical oncology; a manual for students and
doctors. Berlin, New York, Springer-Verlag,
1973

QZ Masson, Pierre
200 Human tumors: histology, diagnosis, and tech-
.M4 nique, 2d ed. Detroit, Wayne State Univ
Press, 1970

QH The Pathology of transcription and translation.
605 New York, M Dekker, 1972
.P2

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PEDIATRICS

- WS Grey, Loren
105 **Discipline without tyranny**; child training during the first five years. New York, Hawthorn Books, 1972
.G8
- WS Symposium on the role of genetics in mental retardation, Miami, 1970.
107
.S9 **The role of genetics in mental retardation.** Coral Gables Fla, Univ of Miami Press, 1971

PHARMACOLOGY

- QV European Society for the study of Drug
38 Toxicity.
.E8 **Toxicological problems of drug combinations.** Amsterdam, 1972
- QV Garb, Solomon
38 **Clinical guide to undesirable drug interactions and interferences.** New York, Springer Pub Co, 1971
.G2
- ZQV Smith, Ralph G
662 **Chlorine**: an annotated bibliography. New York, Chlorine Institute, 1972
.S6
- QV **Rifomycin**: chemotherapy. New York, MSS Information Corp, 1973
350
.R5
- QV Symposium on the Biology of Skin, 20th, Glenden Beach Ore, 1969
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.S9 **Pharmacology and the skin**; proceeding. New York, Appleton-Century-Crofts, 1972

PSYCHIATRY AND PSYCHOLOGY

- HV Cohen, Stanley
8705 **Psychological survival**; the experience of long-term imprisonment. New York, Pantheon Books, 1973
.C6
- WM **Current research in marijuana.** New York, Academic Press, 1972
276
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- WM Ferber, Andrew
430 **The book of family therapy.** New York, Science House, 1972
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- WM Giovacchini, Peter L
460 **Tactics and techniques in psychoanalytic therapy.** New York, Science House, 1972
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- WM Hoch, Paul H
141 **Differential diagnosis in clinical psychiatry.** New York, Science House, 1972
.H6
- WM Huber, Jack T
420 **Goals and behavior in psychotherapy and counseling**; readings and questions. Columbus Ohio, C E Merrill Pub Co, 1972
.H8
- BF **Psychosocial aspects of terminal care.** New York, Columbia Univ Press, 1972
789
.D4
.P7
- BF Roeske, Nancy A
698.4 **Examination of the personality.** Philadelphia, Lea & Febiger, 1972
.R7
- Z Seruya, Flora C
7164 **Sex and sex education**: a bibliography. New York, R R Bowker Co, 1972
.S42
.S4

- WM US National Commission on Marijuana and
276 Drug Abuse
- .U5 **Marijuana, a signal of misunderstanding.** Washington, US Govt Print Off, 1972
- WM Van Riper, Charles Gage
475 **The treatment of stuttering.** Englewood Cliffs, NJ, Prentice-Hall, 1973
.V2
- HQ Vincent, Clark E
728 **Sexual and marital health**: the physician as a consultant. New York, McGraw-Hill, 1973
.V7
- BF Weisman, Avery Danto
789 **On dying and denying.** New York, Behavioral Pub, 1972
.D4

PUBLIC HEALTH

- WA Beck, Alan M
30 **The ecology of stray dogs**; a study of free-ranging urban animals. Baltimore, York Press, 1973
.B3

RADIOLOGY

- WN National Committee on Radiation Protection.
415 **A manual of radioactivity procedures.** Washington, US Govt Print Off, 1961
.N3

UROGENITAL SYSTEM

- WJ Gillette, Paul J
780 **The vasectomy information manual.** New York, Outerbridge & Lazard, 1972
.C4
- WJ Hueper, Wilhelm C
100 **Occupational and environmental cancers of the urinary system.** New Haven, Yale Univ Press, 1969
.H8

HISTORY OF MEDICINE

- ZWZ **Bibliography of the history of medicine.** Bethesda Md, National Library of Medicine, 1970
40
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- History Carmoly, Eliakin
C **History of the Jewish physicians.** Baltimore, John Murphy, 1840
- History Cowie, Leonard W
WC **The black death and peasants' revolt.** London, Wayland Pub, 1972
355
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- History Dunbar, John Richard Woodstock
C **Notes. Surgery of deformities. Club foot.** Baltimore, John Murphy, 1840.
- History Gifford, James F
W **The evolution of a medical center**; a history of medicine at Duke University to 1941. Durham NC, Duke Univ Press, 1972
19
.D8
- AV **History and romance of medicine in Maryland.** Edited by Archie Robert Cohen for Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland. Baltimore, 1973. Tape and slides.
Collection
- History Larrabee, Eric
WX **The benevolent and necessary institution**; the New York hospital, 1771-1971. Garden City NY, Doubleday, 1971
28
.AN7
.N6

List Ten Best Places To Go For Top Care

Can you name the ten best places in the United States to go for hospital care?

Here's how 386 physicians rated them from the standpoint of dispensing outstanding patient care in a poll conducted by *Today's Health* and *Resident and Staff Physician* magazines:

Mayo Tops

Mayo Clinic and its affiliated hospitals of Rochester, Minn was number one with 101 votes. Massachusetts General of Boston, with 99 votes,

was second.

The others, in order, were:

Johns Hopkins, Baltimore, 49; Columbia-Presbyterian, New York City, 28; Peter Bent Brigham, Boston, 27; Cleveland Clinic, 24; U.C.L.A. Center for the Health Sciences, Los Angeles, 16.

And, Mount Sinai, New York City, 15; Barnes, St. Louis, 14; and Ochsner Clinic, New Orleans, 14.

All Teach

All ten hospitals on the list, says the Health Insurance Institute, are teaching institutions and many have strong research programs as well.

The report also noted that nearly one fifth of the doctors listed their own hospitals as among the best.

—Health Insurance Institute

Possibly the first anti-pollution effort in the United States occurred in 1876, when the American Medical Association urged states and cities to guard water supplies against contamination.

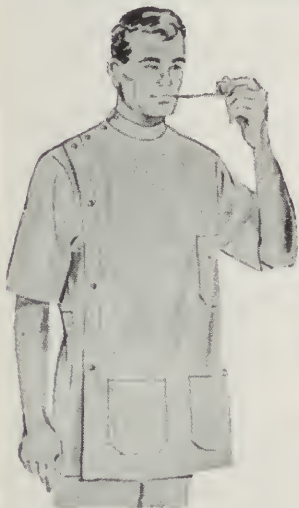
Obstetrician - gynecologists work the most hours per week, 55, while psychiatrists have the shortest workweek, 47 hours, a survey of physicians by the American Medical Association showed.

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"There is no level of smoking which is safe," says Dr Alton Ochsner, Senior Consultant in Surgery at the Ochsner Clinic.

Dr Ochsner, also a former Professor of Surgery at Tulane University and one of the earliest medical authorities to investigate the effects of smoking, makes the statement in a recent issue of *Smoke Signals*.

According to Dr Ochsner, the best way to avoid the bad effects of tobacco is to quit smoking completely.

"After considerable experience in treating patients who are tobacco users, I am convinced that the best way to stop is to abstain completely from it and not taper off," says Dr Ochsner, who has performed some 2,500 operations on lung cancer patients.

"This is particularly true in the individual who has been a heavy smoker and has developed changes which make him more susceptible to the effects of the continued even though decreased use of tobacco."

Dr Ochsner says that some people do have withdrawal symptoms from the lack of nicotine. However, the main problem comes from trying to break the habit of repeatedly smoking a cigarette. It is because of this habit that "for a long period of time an ex-smoker may desire a cigarette," says Dr. Ochsner.

"It is absolutely imperative not to take a single puff, because in that case smoking is likely to be resumed. For the addicted individual it is just as hazardous to take a single cigarette as for the alcoholic to take a single drink."

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The new town of Montgomery Village today is home for 13,000 people.

And one General Practitioner. Village residents depend upon the medical services offered by the men and women of the Montgomery Village Professional Center, located in the heart of beautiful downtown Montgomery Village.

Doctors, specializing in many fields of medical practice, maintain their offices in the Center's contemporary buildings, and utilize the complete laboratory facilities available here. The individual buildings were designed to offer flexibility, to provide you with 850 sq. ft. to 5,000 sq. ft. of space per floor. Suites are arranged to meet your specifications.

By 1980 there will be 30,000 Montgomery Village new town residents. In addition, there'll be nearly 200,000 people in the surrounding Gaithersburg area. The Village needs more doctors, especially more General Practitioners. We'd like you to grow with us.

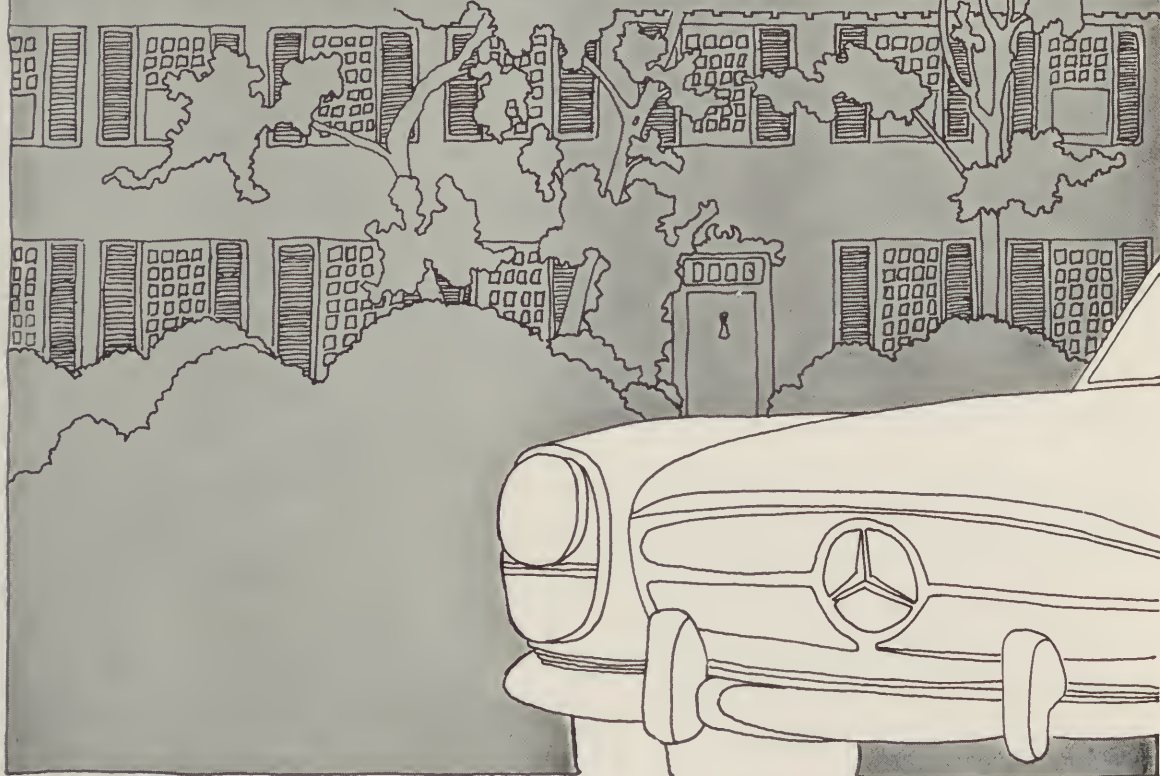
For information concerning office space available in the Montgomery Village Professional Center, and the broad spectrum of rental and for-sale housing found within the Village, write:

Mr. Reed Reutlinger
Kettler Brothers, Inc.
19110 Montgomery Village Avenue
Gaithersburg, Maryland 20760
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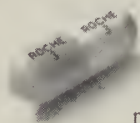
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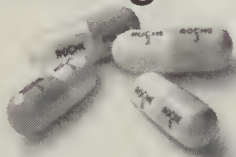
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Librium® 25 mg
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.